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Office of the Inspector General

Wasco State Prison
Medical Inspection Results
Cycle 4

April 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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WASCO STATE PRISON
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Cycle 4

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EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at WSP from October 2015 to January 2016. The inspection included in-depth reviews of 81 inmate-patient files conducted by clinicians, as well as reviews of documents from 438 inmate-patient files, covering 102 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 WSP using 15 health care quality indicators applicable to the institution, made up of 13 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general trained in monitoring medical compliance. Of the 13 primary indicators, eight were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page ii. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at WSP was *inadequate*.

Health Care Quality Indicators

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

Overall Assessment: Inadequate

Overall Assessment Rating:

Inadequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for WSP was *inadequate*. Of the 13 primary (clinical) quality indicators applicable to WSP, the OIG found one *proficient*, eight *adequate*, and four *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found both *proficient*. To determine the overall assessment for WSP, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at WSP.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of more than 1,125 patient care events.[1] Of the 13 primary indicators applicable to WSP, 11 were evaluated by clinician case review; seven were *adequate*, and four 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

- WSP provided efficient access to care. Office technicians attended all morning huddles and had a tracking process to ensure provider follow-up appointments were completed. When a provider clinic was canceled, clinic staff identified patients with urgent appointments and consulted with the chief physician and surgeon to have a provider review the clinic log and eUHR to determine which patients should be seen urgently.

Program Weaknesses — Clinical

- Poor provider assessments and treatment plans contributed to the *inadequate* rating of the institution. The deficiencies covered a wide spectrum of areas, including emergency care, chronic care, reception center, hospital return, and specialty services.

- Specialty services were inadequate. WSP lacked an effective tracking process to ensure specialty reports were retrieved and scanned into the eUHR. The providers even documented

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

in their progress notes that they frequently lacked the specialty reports for review. The numerous missing specialty reports hindered the providers in delivering quality patient care.

- Health information management was inadequate. Frequently, medical records, especially specialty reports, were unavailable or misfiled. Additionally, many progress notes were illegible and difficult to follow.

- The reception center initial screening and follow-up in the housing units were inadequate. The nurses did not always recognize patients whose medical conditions required more focused assessments and consultation with a provider before releasing them to custody. The housing unit nurses did not always follow up on concerns identified during patients' initial screenings.

Compliance Testing Results

Of the 15 total health care indicators applicable to WSP, 12 were evaluated by compliance inspectors.[2] There were 102 individual compliance questions within those 12 indicators, generating 1,417 data points, testing WSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 102 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores for the 12 applicable indicators ranged from 59.9 percent to 100.0 percent, with the primary (clinical) indicator *Diagnostic Services* receiving the lowest score, and the secondary indicator *Job Performance, Training, Licensing, and Certifications* receiving the highest. Of the ten primary indicators applicable to compliance testing, the OIG rated two *proficient,* four *adequate,* and four *inadequate.* Of the two secondary indicators, which involve administrative health care functions, both were rated *proficient.*

Program Strengths — Compliance

As the *WSP Executive Summary Table* on page viii indicates, the institution's compliance ratings were *proficient,* scoring above 85 percent, in the following two primary indicators: *Access to Care* and *Pharmacy and Medication Management*. The institution also received *proficient* scores in the secondary indicators *Internal Monitoring, Quality Improvement, and Administrative Operations* and *Job Performance, Training, Licensing, and Certifications*. The following are some of WSP's strengths based on its compliance scores on individual questions in all the primary health care indicators:

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

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

- Providers conducted timely follow-up appointments for chronic care patients and those who were released from a community hospital and returned to the institution. Also, providers timely evaluated patients assigned to the CTC and timely completed a history and physical.

- Patients had a standardized process to obtain and submit health care service request forms, and nursing staff timely reviewed patients' requests and timely conducted face-to-face visits with patients.

- In all clinics, staff properly sterilized or disinfected reusable invasive and non-invasive medical equipment and properly managed and stored bulk medical supplies.

- For inmate-patients sampled who transferred into WSP from other CDCR institutions or who arrived at WSP's reception center, nurses conducted their initial health screening on the day the patient arrived. Nurses also timely conducted initial assessments for patients assigned to the CTC.

- Nursing staff timely administered or delivered newly ordered medications to patients and timely administered chronic care medications to patients with chronic care illnesses.

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

The following are some of the strengths identified within the two secondary administrative indicators:

- WSP promptly processed inmate medical appeals during the most recent 12 months, and addressed all of the patients' appealed issues for sampled second-level medical appeals.

- The Quality Management Committee met monthly, evaluated program performance and took action when improvement opportunities were identified, and took adequate steps to ensure the accuracy of its Dashboard data reporting.

- All providers, nurses, and the pharmacist-in-charge were current with their professional licenses and certifications; all providers, nurses, and custody staff had current medical emergency response certifications; and the pharmacy and authorized providers who prescribed controlled substances maintained current Drug Enforcement Agency registrations.

- All providers timely received structured clinical performance appraisals, and nurse supervisors completed required reviews of sampled nursing staff.

- All nursing staff hired within the most recent 12 months completed the required new employee orientation training, and sampled nursing staff received annual clinical competency validations.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following four primary indicators: *Diagnostic Services*, *Health Information Management*, *Reception Center Arrivals*, and *Specialty Services*. The following are some of the weaknesses identified by WSP's compliance scores on individual questions in all the primary health care indicators:

- Providers did not conduct timely appointments with patients who, upon their transfer to WSP from another institution, had been referred to a PCP by nursing staff, and did not conduct timely follow-up appointments with patients who had received specialty services.

- Providers did not always review and initial diagnostic reports within the required time frame nor communicate results to the patient.

- Health information management staff did not always properly label patients' electronic health records, and clinicians' signatures on health care documents were often illegible.

- Many exam rooms did not have an adequate environment for providing medical services due to insufficient space, no access to exam tables or tables needing repair, lack of patients' auditory privacy, improperly accessible confidential medical documents, or missing sharps containers.

- For most sampled patients who transferred out of WSP with approved pending specialty service appointments, the institution did not identify the approved services on their health care transfer forms.

- Nursing staff did not always timely administer prescribed medications to patients returning from a community hospital. Also, nurses did not administer all required doses of anti-tuberculosis medications to those who tested positive for tuberculosis and did not follow required protocols for administering and reading annual tuberculosis skin tests.

- Providers often failed to offer or provide required immunizations to patients with chronic care conditions.

- For inmates who arrived at WSP's reception center, nursing staff did not follow required protocols for timely offering and appropriately administering and reading tuberculosis and coccidioidomycosis (valley fever) skin tests. Also, providers did not timely review and communicate intake diagnostic test results to those patients.

- Call buttons in the CTC patient rooms were not working properly, and no interim measures were in place to confirm and document patient welfare.

- Providers did not timely review specialists' reports for high-priority or routine specialty services, and did not timely inform patients when requests for specialty services were denied.

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

WSP Executive Summary Table

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

The *Prenatal and Post-Delivery Services* indicator did not apply to this institution.

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

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

Population-Based Metrics

In general, WSP performed adequately as measured by population-based metrics. In four of the five comprehensive diabetes care measures, WSP outperformed or performed similarly to other State and national organizations. This included Medi-Cal as well as Kaiser Permanente, typically one of the highest-scoring health organizations in California; and Medicaid, Medicare, commercial entities (based on data obtained from health maintenance organizations), and the United States Department of Veterans Affairs (VA). The fifth diabetic measure, patient dilated eye exams, was lower for WSP than for all other entities.

With regard to influenza immunizations, the institution scored much lower than the other entities that reported data; with regard to pneumococcal immunizations, WSP scored higher than Medicare but lower than the VA. For colorectal cancer screenings, WSP scored only slightly lower than Kaiser and the VA, but higher than commercial entities and Medicare. WSP routinely offered inmate-patients these preventive services, but many of them refused the offers; these refusals adversely affected the institution's scores.

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

INTRODUCTION

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

Wasco State Prison (WSP) was the 14th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients with 13 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

Wasco State Prison (WSP) was the first of two reception centers built in Kern County. The primary mission of WSP is to provide short-term housing necessary to process, classify, and evaluate new inmates (physically and mentally) to determine their security level, program requirements, and appropriate institutional placement. A 400-bed medium-custody facility houses general population inmates to help support and maintain the reception center. A minimum-custody facility provides institutional maintenance and landscaping services. The institution runs ten medical clinics where staff handle non-urgent requests for medical services. WSP also treats inmates needing urgent or emergency care in its triage and treatment area (TTA) and treats inmate-patients requiring inpatient health services in the correctional treatment center (CTC). California Correctional Health Care Services (CCHCS) has designated WSP a "basic" care institution. Basic institutions are located in rural areas away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have the capability to provide limited specialty medical services and consultation for a generally healthy inmate-patient population.

In addition, on August 17, 2014, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

According to information provided by the institution, WSP's overall vacancy rate among medical managers, primary care providers, nursing supervisors, and non-supervisory nurses was 27 percent in October 2015. As indicated in the table below, all of the vacancies were among non-supervisory nursing staff; WSP was using 38.25 registry staff to address some of the vacancies. The institution noted on its October 2015 vacancy report that some nursing positions were "hard to fill," due in part to the institution's remote location, and that continual recruitment was ongoing.

WSP Health Care Staffing Resources as of October 2015

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	4	2%	12	7%	12.5	8%	133.7	82%	162.2	100%*
Filled Positions	4	100%	12	100%	12.5	100%	90	67%	118.5	73%
Vacancies	0	0%	0	0%	0	0%	43.7	33%	43.7	27%
Recent Hires (within 12 months)	0	0%	2	17%	2	16%	14	16%	18	15%
Staff Utilized from Registry	0	0%	0	0%	0	0%	38.25	43%	38.25	32%
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%	3	3%	3	3%

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

** Due to rounding, individual percentages for Authorized Positions do not add to exactly 100 percent.*

As of October 12, 2015, the Master Registry for WSP showed that the institution had 4,906 inmate-patients. Within that total population, 1.2 percent were designated High-Risk, Priority 1 (High 1), and 2.4 percent were designated High-Risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. High-risk patients are more susceptible to poor health outcomes than medium- or low-risk patients. High-risk patients 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.

WSP Master Registry Data as of October 12, 2015

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	60	1.22%
High 2	119	2.43%
Medium	1,775	36.18%
Low	2,952	60.17%
Total	**4,906**	**100.0%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At WSP, 15 of the quality indicators were applicable, consisting of 13 primary clinical indicators and two secondary administrative indicators. Of the 13 primary indicators, eight were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

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

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

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

account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

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

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

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

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

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

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

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

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

significant specialty interventions, one cannot conclude that the entire diabetic population is having similarly poor outcomes.

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

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B–1, WSP Sample Sets*, the OIG clinicians evaluated medical charts for 81 unique inmate-patients. *Appendix B, Table B–4, WSP Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 20 of those patients, for 101 reviews in total. Physicians performed detailed reviews of 31 charts, and nurses performed detailed reviews of 22 charts, totaling 53 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Physicians and nurses also performed a limited or focused review of medical records for an additional 4 and 44 inmate-patients, respectively. These generated 1,125 clinical events for review (*Appendix B, Table B-3, WSP Event/Program*). The reporting format 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., three diabetes patients and three anticoagulation patients (*Appendix B, Table B–1, WSP Sample Sets*), the 81 unique inmate-patients sampled included patients with 219 chronic care diagnoses, including 14 additional patients with diabetes (for a total of 17) and two additional anticoagulation patients (for a total of five) (*Appendix B, Table B–2, WSP Chronic Care Diagnoses*). The OIG's sample selection tool evaluated many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by

each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing PCPs care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded the case review sample size was adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *WSP 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 October 2015 to January 2016, deputy inspectors general attained answers to 102 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 438 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of October 26, 2015, field inspectors conducted a detailed onsite inspection of WSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,417 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 WSP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

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

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

After compiling the answers to the 102 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

CCHCS DASHBOARD COMPARISON

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

To derive an overall assessment rating for 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 for the primary quality indicators, which directly relate to the health care provided to inmate-patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators assess the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page ii of this report, 13 of the OIG's primary indicators were applicable to WSP. Of those 13 indicators, eight were rated by both the case review and compliance components of the inspection, three were rated by the case review component alone, and two were rated by the compliance component alone.

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

Summary of Case Review Results: The clinical case review component assessed 11 of the 13 primary (clinical) indicators applicable to WSP. Of these 11 indicators, OIG clinicians rated none *proficient*, seven *adequate*, and four *inadequate*.

The OIG physicians rated the overall adequacy of care of each of the 31 detailed case reviews they conducted. Of these 31 cases, 21 were *adequate*, and 10 were *inadequate.* Of the 1,125 events reviewed, there were 497 deficiencies, of which 55 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There was one adverse event identified in the case reviews at WSP. In case 13, nursing staff performed the initial health screening and documented that the patient had a seizure the day prior. However, they did not consult a provider for an urgent evaluation. Five days later, the patient was found unresponsive, and died despite resuscitation attempts.

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

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
Proficient
(88.2%)

Overall Rating:
Proficient

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *proficient*. The compliance testing was a more targeted approach and was heavily relied upon for the overall rating of this indicator; also, the OIG clinicians identified only minor deficiencies during their case reviews.

Case Review Results

The OIG clinicians reviewed 583 provider and nurse encounters and identified only 30 minor deficiencies relating to *Access to Care*. WSP performed well with regard to *Access to Care*, and the OIG clinicians rated this indicator *adequate*.

Nurse-to-Provider Referrals

Nurses performing sick call assessments are required to refer the patient to a provider if a situation requires a higher level of care. There were 196 outpatient nursing encounters reviewed, and the OIG identified four deficiencies where provider appointments did not occur timely or did not occur at all.

- In cases 4, 20, and 40, the nurse requested a provider appointment, but it occurred beyond the requested time frame.
- In case 52, the nurse requested a routine provider appointment, but it did not occur.

Provider Follow-up After Specialty Service

The providers generally evaluated their patients after specialty services appointments. However, there was one delay:

- In case 78, the provider follow-up visit after an angiogram occurred seven days beyond the requested time frame.

Intra-System Transfer

The OIG found one deficiency among the 11 reviewed patient transfers into WSP:

- In case 8, a patient transferred to WSP from a mental health crisis bed. A provider requested a visit within 30 days to assess the patient's chronic medical conditions. The visit occurred beyond the requested time frame.

Follow-up After Hospitalization

Thirty-two hospital or outside emergency department events were reviewed. The providers timely assessed all patients returning from the higher level of care. However, in cases 3, 5, and 77, the follow-up provider visit occurred beyond the required time frame.

Urgent and Emergent Care

Providers generally saw patients timely after they were evaluated in the triage and treatment area (TTA). Among 39 urgent and emergent encounters reviewed, there were two provider follow-up deficiencies:

- In case 25, on two occasions, the patient was evaluated in the TTA for a seizure. The providers requested three-day and five-day follow-up appointments, but they did not occur.

Deficiencies were found in the institution's timeliness in transporting patients out of the TTA:

- In case 2, the TTA departure to the outside community hospital was delayed 30 minutes due to prison staff's failure to timely prepare the patient for transportation.

- In case 3, the custody transportation team arrived in the TTA 11 minutes after emergency medical services (EMS), thus delaying the departure of the patient, who had lost consciousness after an altercation.

- In case 5, the departure to the outside community hospital was also delayed 21 minutes due to the facility process.

- In case 25, another delay came when EMS arrived in the TTA prior to the custody transportation team preparing the patient for transportation.

A third type of *Access to Care* deficiency related to delays in the initial provider assessment during emergent events:

- In case 78, on three separate occasions, the TTA nurse delayed contacting the provider when the patient presented with chest pain. The delays were 50 minutes, 35 minutes, and 45 minutes after the patient arrived in the TTA.

Specialized Medical Housing

The provider saw patients in the correctional treatment center (CTC) appropriately and timely.

Clinician Onsite Inspection

- The OIG clinicians interviewed WSP staff regarding issues with access to care. Yard clinic nurses reviewed sick call requests and addressed them timely. Nurses stated that the providers were available for consultation throughout the day.

- The OIG clinicians attended three clinic huddles, which were well attended by nurses, providers, medication nurses, nurse assistants, office technicians, and custody officers. These meetings were productive, as pertinent matters were discussed regarding nurse and provider lines, as well as any custody issues related to access to care. Clinic nurses reported seeing eight to ten patients each day on the nurse line and that they did not have backlogs. The providers saw about 14 scheduled patients each day with no backlogs. Office technicians had a tracking process to ensure provider follow-up appointments were completed. When a provider clinic was canceled, clinic staff identified patients with urgent appointments and consulted with the chief physician and surgeon to have a provider review the clinic log and eUHR to determine which patients should be seen urgently.

Compliance Testing Results

The institution received a *proficient* compliance score of 88.2 percent in the *Access to Care* indicator, scoring in the *proficient* range in six of the nine areas tested, as described below:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all six housing units inspected (MIT 1.101).

- Inspectors sampled 35 Health Care Services Request forms submitted by patients across all facility clinics. Nursing staff reviewed 34 of the 35 request forms (97 percent) on the same day they were received. One form lacked nursing initials and the date reviewed (MIT 1.003). Also, nursing staff completed a face-to-face encounter with 100 percent of those patients within one business day of reviewing (or receiving) the requests (MIT 1.004).

- The OIG reviewed recent appointments for 30 inmate-patients who suffered with one or more chronic care conditions, and found that 28 (93 percent) had received timely follow-up

appointments. One of the untimely follow-up appointments was three months late, but the other appointment was only two days late (MIT 1.001).

- Among the sampled 27 inmate-patients discharged from a community hospital, 25 (93 percent) received or were offered a follow-up appointment with a PCP within five days of discharge. The two other patients were seen one and three days late (MIT 1.007).

- Of the seven patients whom nursing staff referred to a PCP and for whom the PCP subsequently ordered a follow-up appointment, six patients (86 percent) received their follow-up appointments timely. One patient received his follow-up appointment 69 days late (MIT 1.006).

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

- Among ten service requests sampled on which the nursing staff referred the patient for a PCP appointment, eight of the patients (80 percent) received a timely appointment. One patient received his follow-up appointment seven days late, and another patient did not receive an appointment for the referred condition (MIT 1.005).

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

- Inspectors sampled 23 inmate-patients who received a high-priority or routine specialty service; 17 of them (74 percent) received a timely PCP follow-up appointment. Three patients' high-priority specialty service follow-up appointments were scheduled 6 to 12 days late. For two other patients who had received a routine specialty service, the PCP met with the patient following their specialty service but did not document any discussion of the specialty service in the provider progress notes. For another patient who received a routine specialty service, there was no evidence in the eUHR that a follow-up appointment occurred at all (MIT 1.008).

- Inmate-patients who transferred into WSP from other institutions with a pre-existing chronic care PCP follow-up need, or with a new PCP referral from WSP's screening nurse, did not always receive a timely PCP visit. Of the 21 patients sampled, only 15 (71 percent) received a timely appointment. Providers saw six patients from 6 to 31 days late (MIT 1.002).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(59.9%)

Overall Rating:
Adequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*. The OIG's case review and compliance testing revealed that providers did not always timely scan diagnostic test results into patients' eUHR, and did not always properly document their review of diagnostic test results and their timely communication of those results to patients. However, OIG's case review found that providers' patient encounter progress notes provided evidence of their review of diagnostic test results and discussion of the results with patients.

Case Review Results

The OIG clinicians reviewed 224 diagnostic services events and found 56 deficiencies. Of those 56 deficiencies, 50 were related to the health information management process. Generally, tests were performed as ordered and reviewed timely by providers, and results were quickly relayed to patients.

In the one significant deficiency, there was delayed communication of a critical lab result to the provider:

- In case 29, the laboratory result was a glucose level of 545 mg/dL (400 mg/dL and above is critically high). The provider was not aware of this result until two days later.

Staff performed most laboratory tests, x-rays, and EKGs as ordered; however, laboratory tests or x-rays were not completed as ordered in the following cases:

- In case 5, a complete metabolic panel was performed ten days late.
- Also in case 5, an abdominal x-ray was performed seven days late.

- Again in case 5, a kidney, ureter, and bladder x-ray was not performed.
- In case 37, an INR (blood test for monitoring blood-thinning) was not performed.
- In case 76, a chest x-ray was not performed.

Health information management contributed to many *Diagnostic Services* deficiencies.

- In cases 3, 5, 7, 11, 16, 17, 18, 24, 25, 27, 29, 33, 34, 35, and 37, x-ray reports were not scanned into the eUHR.
- In cases 25 and 27, laboratory reports were not scanned into the eUHR.
- In case 30, a pathology report was not scanned into the eUHR.
- In cases 4, 6, 7, 11, 16, 17, 24, 26, 27, 30, 31, 33, and 35, diagnostic reports were not properly signed or dated by providers.

Conclusion

The OIG clinicians rated *Diagnostic Services* at WSP *adequate* because the improperly processed diagnostic orders were infrequent. In addition, while numerous diagnostic reports were not scanned into the eUHR and were not properly signed or dated by providers, the providers were aware of the results.

Compliance Testing Results

The institution received an *inadequate* compliance score of 59.9 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- In nine of the ten radiology services sampled (90 percent), the service was performed timely. One patient received the radiology service one day late (MIT 2.001). However, radiology reports were not found in the eUHR for any of the ten samples, precluding the OIG from determining whether radiology reports were reviewed by providers within two business days of receipt. The institution scored zero on this test (MIT 2.002). Providers communicated the radiology results timely to only six of the ten sampled patients (60 percent). To one patient, the provider communicated the results one day late; for two other patients, there was no evidence in the eUHR that a provider communicated the radiology results at all; and for another patient, the provider signed the Notification to the Inmate form (CDCR Form 7393), but did not date it (MIT 2.003).

Laboratory Services

- In all ten of the laboratory services sampled (100 percent), inspectors found the services were timely performed (MIT 2.004). However, diagnostic report results were not timely reviewed by the ordering provider in 50 percent of the samples tested. The provider reviewing the diagnostic report did not date the report, did not sign the report, or did neither (MIT 2.005). Also, providers communicated the diagnostic test results timely to only six of the ten sampled inmate-patients (60 percent). For two patients, the provider's communication was one to four days late. In two other instances, there was no evidence in the eUHR that the provider communicated the results to the patient (MIT 2.006).

Pathology Services

- The institution timely received the final pathology report for eight of ten patients sampled (80 percent). One patient's report was received one day late, and, for another patient, inspectors could not find the report in the patient's eUHR at all (MIT 2.007). Of the nine sampled patients for whom reports were available, inspectors found that providers documented sufficient evidence of their review of the pathology results of only one of them (11 percent). For seven patients, providers failed to initial and date the report evidencing their review of the final results; for the remaining patient, the provider reviewed the report one day late (MIT 2.008). One of those nine patients was sent out to the hospital and subsequently transferred to another institution before the provider could communicate the results. However, of the remaining eight sampled patients, providers timely communicated the final pathology test results to seven of them (88 percent). The provider communicated the results 26 days late to one patient (MIT 2.009).

Recommendations

No specific recommendations.

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 54 urgent or emergent events and found 51 deficiencies in a variety of areas, but most of them were minor and unlikely to affect patient care.

Provider Performance

The WSP providers generally evaluated the patients timely and made appropriate assessments and plans during urgent or emergent events. The OIG identified nine deficiencies, three of which were significant. These cases are also described in the *Quality of Provider Performance* indicator:

- In case 5, the patient was recently discharged from an outside hospital with a diagnosis of epigastric pain with possible gastritis. The provider had no clear working diagnosis for the abdominal pain yet prescribed ketorolac and ibuprofen (nonsteroidal anti-inflammatory drugs), placing the patient at risk of a gastric bleed. The provider also failed to address a critically high blood pressure of 205/110 mmHg, further placing this patient at risk of harm.

- In case 20, a provider evaluated the patient for lightheadedness and slow heart rate of 40 beats per minute. The provider should have reviewed the patient's current medications and withheld propranolol, a medication that can slow the heart rate.

- In case 25, a provider was consulted for evaluation of an acute seizure, but failed to document this event. The provider also failed to check urgent lab test results to rule out low blood sugar as the cause of the seizure, and failed to order other lab chemistries to check for blood levels of electrolytes and seizure medication.

The following minor deficiencies were also identified in emergency care:

- In case 6, the provider did not document a telephone consultation with a patient with pain and numbness in his right arm.
- In case 24, the provider did not document a telephone consultation with a patient with chest pain.
- In case 25, on three occasions, the provider did not document a telephone consultation with a patient having seizures.

Nursing Performance

Nurses generally evaluated patients timely and made appropriate assessments and interventions during urgent or emergent events. The OIG identified 24 nursing deficiencies, two of which, both in case 2, were significant:

- In case 2, the emergency response was inadequate. Custody officers failed to check the patient's airway, breathing, and pulse and did not assist the nurse with CPR. The first medical responding LVN failed to follow 2010 American Heart Association guidelines for an unresponsive patient with abnormal breathing. In addition, there was no documentation of the reason the nurse stopped CPR and did not use an automatic external defibrillator. Although the patient survived, the nurse's action could have resulted in patient harm. Later, the TTA RN failed to notify the physician on call regarding a blood pressure of 209/91 mmHg, and failed to document allergies, current medications, and medical diagnoses prior to transferring the patient to a higher level of care.
- Nurses did not monitor vital signs or patients' conditions at appropriate intervals in cases 3, 5, 7, 24, 77, and 78.
- Nurses performed incomplete assessments in cases 5, 6, and 78.
- In case 78, nurses delayed contacting a provider on three occasions.

Emergency Medical Response Review Committee (EMRRC)

The committee generally reviewed all emergency medical response incidents and took necessary actions to improve the institution's emergency medical response. There were five deficiencies:

- In case 2, the EMRRC reviewed the case and determined that staff acted outside of compliance and that training was necessary. However, the committee did not identify the specific noncompliant issues nor describe the specific training required.

- In cases 2, 3, 5, and 25, the EMRRC did not identify that custody transportation teams arrived after EMS, delaying the patients' transfer to emergency departments. These delays are also discussed in the *Access to Care* indicator.

Onsite Clinical Inspection

At the time of the OIG clinicians' onsite inspection, the TTA had two beds and ample space for patient evaluation, with working areas for both nurses and providers. There was adequate lighting and it was appropriately stocked with medications and medical equipment, such as an automated external defibrillator and a crash cart. WSP provided adequate privacy when patients received medical examinations. The nurses stated that the providers were readily available for consultations.

The chief nursing executive addressed the significant nursing and custody deficiencies in case 2 and explained that during that incident, nursing and custody staff were overwhelmed, managing a riot with several injured inmates on the yard.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(74.1%)

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 inmate-patient's eUHR; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

Case Review Results

The OIG clinicians identified 150 *Health Information Management* deficiencies.

Hospital Records

- Most hospital records were timely retrieved, reviewed, and scanned into the eUHR. However, many hospital discharge summaries were not properly initialed by a provider. This deficiency occurred in cases 5, 6, 7, 11, 22, 24, 25, 28, and 33.

Missing Documents (Progress Notes and Forms)

- Most nursing and provider progress notes were scanned into the eUHR; however, in cases 11, 24, 25, 55, 60, 63, 65, and 67, progress notes were missing. In case 25, there was no provider progress note documenting decision-making in evaluating the patient for an acute seizure.

- In cases 24, 25, 77, and 88, documents were missing. In case 24, there was no documentation showing that warfarin (blood thinner) was given to the patient as ordered.

Scanning Performance

- There were mislabeled or misfiled documents in cases 6, 21, 24, 28, 77, 78, and 84. In case 21, the specialized medical housing discharge instructions of a different patient were scanned into this patient's eUHR.

Specialty Services Reports

- The most severe deficiencies occurred when specialty reports were not retrieved or scanned into the eUHR. These types of records contained vital information and recommendations to assist the providers in patient care. In cases 4, 5, 6, 7, 11, 15, 17, 20, 21, 24, 25, 27, 28, 32, and 36, specialty reports were not scanned into the eUHR. In case 7, a cardiologist evaluated the patient and documented "full dictation attached," but no attachments were scanned into the eUHR.

- Deficiencies in the processing of specialty reports occurred frequently. A provider did not properly sign 15 of the 184 specialty reports.

Diagnostic Reports

- WSP had problems with the retrieval and review of diagnostic reports. These findings are discussed in detail in the *Diagnostic Services* section.

Legibility

- Illegible progress notes, signatures, and initials were found from both nurses and providers.

Compliance Testing Results

The institution received an *inadequate* compliance score of 74.1 percent in the *Health Information Management (Medical Records)* indicator. Although WSP scored well in five of the eight tests conducted, improvement is needed in the three areas below, which dropped the score significantly.

- The institution scored zero in its labeling and filing of documents scanned into inmate-patients' eUHRs. The most common errors were incorrectly labeled documents (MIT 4.006).

- When the OIG reviewed various medical documents, such as hospital discharge reports, initial health screening forms, certain medication administration records, and specialty service reports, to ensure that clinical staff legibly documented their names on the forms, only 23 of 40 samples (58 percent) showed compliance (MIT 4.007).

- The OIG reviewed hospital discharge reports or treatment records of 27 sampled patients who were sent or admitted to the hospital to determine if a WSP provider reviewed the records within three calendar days of the patients' discharge and to ascertain whether key elements were included in the documentation. Providers timely reviewed the records for only 19 patients (70 percent). For seven patients, providers reviewed the records one to two days late; for another patient, the provider reviewed the records 18 days late (MIT 4.008).

The institution performed in either the *proficient* or the *adequate* range in the following tests:

- WSP staff timely scanned all 20 sampled miscellaneous non-dictated documents into the patient's eUHR within three calendar days of the patient encounter date. These documents included providers' progress notes, inmate-patients' initial health screening forms, and health care services request forms (MIT 4.001).

- For all 20 hospital discharge reports sampled, WSP staff scanned the reports into the inmate-patient's eUHR file within three days of the patient's discharge (MIT 4.004).

- Staff timely scanned medication administration records (MARs) into patients' eUHR files for all 20 sampled documents (MIT 4.005).

- For 17 of 20 specialty service consultant reports sampled (85 percent), WSP staff scanned the reports into the inmate-patient's eUHR file within five calendar days. Three documents were scanned from one to nine days late (MIT 4.003).

- Inspectors tested five PCP-dictated progress notes to determine if staff scanned the documents within five calendar days of the patient encounter date; four of the five documents (80 percent) were scanned timely. Staff scanned the other document one day late (MIT 4.002).

Recommendations

No specific recommendations.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(81.7%)

Overall Rating:
Adequate

Clinician Comments

Although OIG clinicians did not rate the health care environment at WSP, they obtained the following information during their onsite visit:

- WSP medical clinics had adequate space needed to provide patient care with auditory privacy. Some exam rooms had glass doors, but providers had access to partitions that could be used to provide patients with visual privacy. The clinics had ample lighting and were well-stocked with medications and medical equipment.

- The triage and treatment area (TTA) had two beds and adequate space for patient evaluation, with working areas for both nurses and providers. The TTA also had ample lighting and was well-stocked with medications and medical equipment, such as an automated external defibrillator (AED) and an emergency crash cart.

- Reception center observations are discussed under the *Reception Center Arrivals* indicator.

Compliance Testing Results

The institution received an *adequate* score of 81.7 percent in the *Health Care Environment* indicator, scoring well in several test areas, as described below:

- Clinical health care staff in all 12 clinics properly sterilized or disinfected reusable invasive and non-invasive medical equipment, as warranted (MIT 5.102).

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

- All 12 clinics followed adequate medical supply storage and management protocols (MIT 5.107).

- Inspectors examined emergency response bags to determine if the bags were inspected daily and inventoried monthly, and whether they contained all essential items; bags were compliant in nine of the ten clinical locations where they were stored (90 percent). While medical staff inspected and inventoried all emergency response bags at required intervals, an oxygen tank that accompanied one response bag was missing a pressure gauge (MIT 5.111).

WSP scored in the *adequate* range in the five following areas:

- The institution appropriately disinfected, cleaned, and sanitized 10 of the 12 clinics observed (83 percent). In the administrative segregation unit (ASU) medication room that was being used (on a temporary basis) to conduct patient exams during clinic construction, the floor was dirty; in the CTC, there was dirt buildup and a spider web in the outside corner of one patient's treatment room (MIT 5.101).

- There were operable sinks and sufficient quantities of hygiene supplies in 10 of the 12 clinics inspected (83 percent). In two clinics, inmate restrooms lacked hand hygiene supplies, such as antiseptic soap and disposable paper towels (MIT 5.103).

- OIG inspectors observed clinicians' encounters with patients and found that in 10 of the 12 clinics (83 percent), clinicians followed good hand hygiene practices. However, at one clinic, the provider did not wash his hands prior to putting on gloves; in another clinic, the provider did not wash his hands after removing gloves that came into contact with bodily fluids (MIT 5.104).

- Ten of the 12 clinics' common areas (83 percent) had an environment conducive to providing medical services. At the Yard A facility, health care staff performed vital sign checks in the hallway where other patients waited, compromising auditory privacy. In the ASU, the room temporarily being used to conduct patient exams was small and its narrow entryway prevented access for patients in wheelchairs. Although staff indicated that exams were conducted at another facility clinic for those patients, each clinic was required to have at least one exam room that could accommodate patients in wheelchairs for cases in which emergent care was needed (MIT 5.109).

- Inspectors found the institution furnished 9 of its 12 clinics (75 percent) with essential supplies and core equipment necessary to conduct a comprehensive exam. Two or more deficiencies were found in the TTA and in clinical areas within the ASU and the receiving and release area (R&R). Specifically, the following items were missing: exam tables, hemoccult cards and developer (in provider exam areas), Snellen vision charts with a permanent distance marker, disposable tips for an otoscope, a weight scale, and a currently calibrated EKG machine (MIT 5.108).

While the institution performed well in most of the tests in this indicator, the following two areas presented opportunity for improvement:

- Only 5 of WSP's 12 clinics (42 percent) had sufficient space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical exam. In the ASU medication room that was temporarily being used as a clinical exam room, the space was inadequate to conduct a proper patient exam (Figure 1). Similarly, the institution's R&R exam room did not provide adequate space to conduct patient exams. In the CTC, the placement of the exam table prevented patients from lying in a fully extended position on the table (Figure 2). Also, a PCP exam room in one facility's clinic did not provide patients with auditory privacy; in two other clinics, patients' confidential medical records designated for shredding were either visually or physically accessible to other inmates. In addition, two exam rooms had exam tables with torn vinyl areas that staff could not adequately disinfect and that could harbor infectious agents (MIT 5.110).

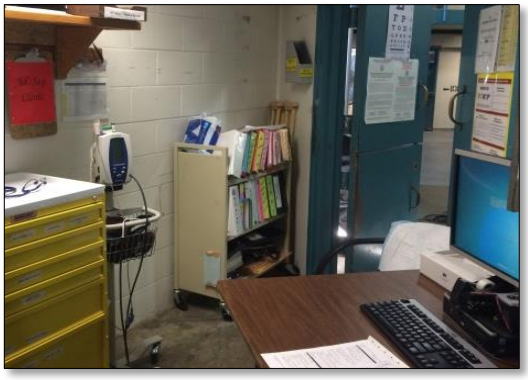

Figure 1: ASU medication room temporarily being used for exams

Figure 2: Poorly placed exam table in the CTC

- In seven of WSP's 12 clinics (58 percent), proper protocols were followed to mitigate exposure to blood-borne pathogens and contaminated waste; five clinics had exam rooms without sharps containers (puncture resistant containers used for expended syringes) (MIT 5.105).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide adequate health care services. The OIG did not score this question. When OIG inspectors interviewed health care management, staff did not have concerns about the facility's infrastructure or its effect on staff's ability to provide adequate health care. At the time of the inspection, the institution had a master infrastructure project underway, which included renovation of, or addition to, WSP's existing clinics in Facilities A, B, C, and D, the reception center, and the central health services building. According to management, the project was on track with a targeted completion date in June 2017 (MIT 5.999).

Recommendation for CCHCS

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

Recommendations for WSP

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

- All clinical areas consist of a full complement of core medical equipment that includes a Snellen vision chart with a permanent distance marker, disposable tips for the otoscope, and a weight scale.
- Staff regularly monitor calibration expiration dates for applicable medical equipment.
- Each clinic has a wheelchair-accessible exam room.
- Each exam room has an exam table in the immediate area, a sharps container, and hemoccult cards and a developer (in provider exam rooms).
- Auditory privacy is provided for patients being examined or triaged in all clinic common areas and exam areas, and patients' confidential medical records are shredded or secured so they are inaccessible to other inmates and non-health-care staff.
- All exam settings are arranged so that a patient can lie fully extended on the exam table and have sufficient space for the provider to conduct a thorough examination.
- Torn areas on vinyl-covered exam tables are repaired or the tables are replaced.
- Clinics are cleaned each day they are operational; all floor and countertop surfaces are regularly cleaned, including corners and other hard-to-reach locations; and all clinic restrooms are stocked with disposable paper towels and antiseptic soap.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(75.1%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 27 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. The OIG clinicians also reviewed 45 hospitalization events, each of which resulted in a transfer back to the institution. In general, the inter- and intra-system transfer processes at WSP were adequate, so the case review rating for this indicator was *adequate*.

Transfers In

WSP processed patients from other CDCR institutions appropriately, medications were continued without missed doses, and the medical care was timely.

Transfers Out

The deficiencies found for patients transferring out of WSP were mainly due to incomplete nursing documentation of significant medical information on the Health Care Transfer Information form (CDCR Form 7371). There was no system in place to communicate provider encounters or orders that occurred after transfer forms were completed. The following deficiencies were found:

- In case 37, significant medical information was not communicated to the receiving institution. The provider wrote an order two days before transfer for a repeat chest x-ray in one to two days to assess an abnormal finding. The order was scanned that day, but the nurse

included neither the abnormal x-ray result nor the order for repeat chest x-ray on the transfer form. A repeat chest x-ray was done at the receiving institution three weeks later and showed a progression of the pulmonary infiltrates, and the patient was hospitalized for pulmonary edema.

- Also in case 37, the patient had an arteriovenous graft (surgical access site created for dialysis), which had clotted in the past, and was taking warfarin, a blood thinner. On the day of transfer, the provider ordered an increased dose of warfarin, which was scanned on the day after transfer. The receiving institution was not informed of the increased dose and continued the lower dose for three weeks.

- Again in case 37, the provider completed a consultation for medication management prior to tooth extractions. The consultation was scanned two days before the transfer, but was not included on the transfer form.

- In case 38, the patient was transferred on the day before dialysis was due. The receiving institution was not informed of the dialysis schedule, and the patient did not receive dialysis timely. The patient developed an abnormally high potassium level, which placed him at risk for cardiac arrhythmia.

- Also in case 38, the nurse did not include on the transfer form that the patient had laser eye surgery the previous day, and needed a follow-up specialty visit in three to four weeks. However, the specialty visit was ordered at the receiving institution after the patient complained of vision problems.

- In case 77, the nurse did not include on the transfer form the patient's diagnosis of obstructive sleep apnea, which needed a continuous positive airway pressure machine to help the patient breathe while asleep.

- Also in case 77, the nurse did not include that the patient had a wound on his toe requiring dressing changes.

- In case 80, the patient required a comprehensive nursing care plan due to quadriplegia (paralysis of both arms and legs). Although there was a provider-to-provider discussion prior to the transfer, there was no nursing discharge summary nor care plan for the patient's decubitus ulcer (bed sore), the need for fall precautions, his extensive medical equipment, or the pain management for the patient. This deficiency is also addressed in the *Specialized Medical Housing* indicator.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during any transfer. The OIG clinicians reviewed 60 hospital return events and found 25 deficiencies. Provider follow-up visits did not always occur timely, and not all hospital recommendations were addressed. All patients returning from hospitalization and emergency department visits were evaluated by a nurse in the triage and treatment area before returning to their housing unit. Fifteen hospital discharge summaries were scanned into the eUHR without a provider signature. Thus, it was uncertain that the providers reviewed the hospital discharge summaries and addressed all findings and recommendations.

- In case 21, the patient returned from hospitalization with an open incisional wound requiring wet-to-dry dressings twice a day. The nurse failed to advocate for the patient to be admitted to the CTC for wound care and close monitoring. He was admitted to the CTC the next day.

- In case 28, on three occasions, the patient did not receive an antiarrhythmic medication as recommended by the hospitalist. This case is also discussed in the *Quality of Provider Performance* indicator.

- In case 77, the patient was hospitalized for chest pain, and the provider follow-up visit occurred beyond the required time frame.

Clinician Onsite Inspection

The OIG clinicians were informed that the medical records supervisor worked with the utilization management nurse to ensure hospital discharge summaries were received, signed, and scanned. Patients returning from hospitalization and emergency department visits were evaluated by a nurse in the TTA. Two nurses were assigned to complete health care transfer information forms for patients who were leaving the institution.

Conclusion

The transfer-in process and hospital return process at WSP were found to be *adequate*. Deficiencies found with patients transferring out of WSP were mostly due to incomplete nursing documentation of significant medical information on the health care transfer information form. Two of these deficiencies were due to providers' orders that were not yet scanned into the electronic medical record, and, in one case, pre-transfer scheduling for hemodialysis was not completed. The OIG is looking forward to the new CCHCS transfer policy, which may improve the transfer process.

Compliance Testing Results

Wasco State Prison obtained an *adequate* compliance score of 75.1 percent in the *Inter- and Intra-System Transfers* indicator, scoring in the *proficient* and *adequate* ranges in three of the five tests, as described below:

- The OIG tested 25 patients who transferred into WSP from another CDCR institution and found that nursing staff timely completed a health screening assessment on the same day of the patient's arrival for 24 of the patients (96 percent). In one instance, nursing staff neglected to answer all applicable questions on a patient's Initial Health Screening form (CDCR Form 7277) (MIT 6.001).

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

- Nine of the sampled inmate-patients who transferred into WSP had an existing medication order upon arrival. Seven of the nine patients (78 percent) received their medications without interruption. Two patients received scheduled doses of their medication one day late (MIT 6.003).

The institution has an opportunity to improve in the two areas described below:

- The institution scored 35 percent when the OIG tested 20 inmate-patients who transferred out of WSP to another CDCR institution to determine whether WSP listed the patients' scheduled specialty service appointments on the Health Care Transfer Information form (CDCR Form 7371). Nursing staff failed to include specialty service appointments approved at WSP on the transfer forms for 13 patients (MIT 6.004).

- The transfer packages for two of the three inmate-patients tested who transferred out of the institution during the onsite inspection (67 percent) included required medications and related documentation. The third patient's transfer package did not include his KOP medication (MIT 6.101).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Adequate
Compliance Score:
Proficient (87.8%)

Overall Rating:
Adequate

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 PCP prescriber, staff, and patient.

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*. There were many case review deficiencies related to the institution untimely administering medications to patients for both new prescriptions and renewals. Compliance inspectors identified similar deficiencies during their testing for the sub-indicator Medication Administration, which scored within the *adequate* range. As a result, the case review rating of *adequate* was deemed a more appropriate reflection of the overall indicator rating.

Case Review Results

The OIG clinicians evaluated *Pharmacy and Medication Management* as it related to the quality of clinical care provided. The clinicians identified 42 deficiencies related to pharmacy and medication management. The case review rating for *Pharmacy and Medication Management* was *adequate*.

New Prescriptions

Case reviews showed that patients usually received their medications timely and as prescribed. However, in five cases, prescriptions were not processed timely:

- In case 7, there was no documentation that the patient received his sublingual nitroglycerin.
- In case 24, enoxaparin, a blood thinner, was not administered to the patient timely.
- In case 33, an order for warfarin, a blood thinner, was started one day late.
- In case 59, an order for an antibiotic to treat bronchitis was started three days late.

- In case 78, the provider prescribed ibuprofen in the triage and treatment area, but there was no documentation that the patient received the medication.

Chronic Care Medication Continuity

WSP performed poorly in chronic care medication continuity, displaying the following deficiencies:

- On two occasions in case 6, the patient did not receive hydroxyurea (a chemotherapy medication). There was no documentation as to the reason the doses were missed. On another occasion, the nurse administered the wrong amount of the medication.

- In case 16, the patient experienced a delay in receiving a refill of Nephro-vite (vitamins for kidney failure patients).

- In case 18, the dialysis-dependent patient with kidney failure experienced a delay in receiving sevelamer (a medication to lower a phosphate buildup in the blood).

- In case 25, the provider failed to reorder the seizure medication topiramate, which placed the patient at risk of further seizures.

- In case 75, the patient had insulin-dependent diabetes. A morning dose of insulin was missed when his insulin prescription expired.

Intra-System and Intra-Facility Transfers and Medication Continuity

Medication continuity was maintained in the majority of the reviewed transfer cases. However, there was one deficiency:

- In case 22, as the patient was transferred from the CTC to the general population, two doses of clindamycin, an antibiotic, were not administered.

Reception Center

- In case 76, the patient arrived from a county jail and did not receive his blood pressure medications. Subsequently, the patient developed dizziness and a very high blood pressure of 230/120 mmHg. The patient required transfer to a higher level of care at an outside community hospital.

- In case 77, the patient arrived from a county jail and did not receive his ticagrelor, a platelet inhibitor, for more than three weeks. This was due to a delay in the provider submitting a non-formulary request.

Post-Hospitalization Medication Continuity

The OIG clinicians identified significant deficiencies in post-hospitalization medication continuity in two cases:

- In case 4, the patient returned from hospitalization and did not receive his blood pressure medications for two days.

- In case 28, on three occasions, as the patient returned from hospitalization for paroxysmal atrial flutter (irregular heart rhythm) with the recommendation to continue amiodarone for heart rate control, the providers did not order the medication.

Medication Administration

Case review found the following deficiencies in medication administration:

- In case 16, the patient was scheduled for surgery, but nursing staff gave the patient aspirin despite an order to hold the medication, so the surgery had to be rescheduled.

- In case 17, the provider increased the metformin (diabetes medication) to 1000 mg twice daily, but the order was not filled. The provider identified the error three weeks later.

- In case 18, simvastatin (cholesterol-lowering medication) was expired and not filled until seven weeks later.

- In case 19, the second dose of the patient's hepatitis B vaccine was administered four weeks late.

- In case 23, the provider ordered discontinuation of amiodarone (heart rhythm medication). Nursing staff, however, did not instruct the patient to stop taking the medication. The provider identified the problem ten days later.

- In case 24, the provider increased warfarin (blood thinner) from 4 mg to 6 mg daily. However, both the 4 mg and 6 mg doses were administered that evening, and there was no indication that the error was identified.

- In case 73, the medication nurse checked the patient's blood pressure, which was elevated at 177/108 mmHg. The nurse noted the patient had not yet taken his keep-on-person medications. However, the nurse failed to take any action, such as notifying the clinic nurse, asking the patient if he had any symptoms like headaches or dizziness, or instructing the patient to return to recheck his blood pressure after taking the medications.

- In case 77, the provider increased lisinopril (blood pressure medication) to 20 mg daily. However, the medication administration record did not have the increased dose documented.

Clinician Onsite Inspection

The pharmacy demonstrated proper logging procedures and ensured that medications were well stocked in the Omni-cell. The pharmacy staff informed providers one week before medications expired.

Compliance Testing Results

The institution received a *proficient* compliance score of 87.8 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: Medication Administration, Observed Medication Practices and Storage Controls, and Pharmacy Protocols.

Medication Administration

This sub-indicator category consists of six applicable questions, in which the institution received an average score of 81 percent. The institution scored well in the following areas:

- Inspectors found that 29 of the 30 patients sampled (97 percent) received their new medication orders in a timely manner. One patient received his medication one day late (MIT 7.002).

- Chronic care medications were provided timely to 14 of the 15 patients sampled (93 percent). One patient received his medication three days late (MIT 7.001).

- The institution scored 86 percent in delivering and administering medications to inmate-patients received from a county jail. Only one of the seven sampled patients did not receive his prescribed medication in a timely manner upon arrival at WSP (12 days late) (MIT 7.004).

- WSP ensured that 25 of 30 patients sampled (83 percent) received their medications without interruption when they transferred from one housing unit to another; the remaining five patients did not receive their medication at the proper dosing interval (MIT 7.005).

The institution has an opportunity to improve in the following medication administration areas:

- Clinical staff timely provided new and previously prescribed medications to only 16 of 27 patients sampled who had been discharged from a community hospital upon their return to the institution (59 percent). Nine patients received their nurse-administered and KOP medications from one to three days late; another patient received his KOP medication 13 days late. For one other patient, there was no evidence found in the eUHR that the patient received his prescribed nurse-administered antiseptic mouthwash (MIT 7.003).

- Nursing staff administered medications without interruption to seven of ten inmate-patients (70 percent) who were en route from one institution to another and had a temporary layover at WSP. For three inmate-patients temporarily housed at WSP, there was no indication in the eUHR that the medications were administered (MIT 7.006).

Observed Medication Practices and Storage Controls

This sub-indicator category consists of six applicable questions, in which the institution received an average score of 86 percent. The institution received scores of 100 percent in the following three areas:

- The institution properly stored non-narcotic medications that did not require refrigeration at all 16 of the applicable clinics and medication line storage locations (MIT 7.102).

- At all six medication preparation and administration locations inspected, nursing staff followed proper hand hygiene contamination control protocols (MIT 7.104).

- Also, nursing staff at all six of the inspected medication preparation and administration locations followed appropriate administrative controls and protocols during medication preparation (MIT 7.105).

The institution performed adequately in the following areas:

- The institution employed adequate medication security controls over narcotic medications in 11 of the 13 clinic and medication line locations inspected that stored narcotics (85 percent). In medication areas, policy requires that nurses ensure that controlled substances are securely maintained and locked up; only one nurse per shift should maintain the keys. At two clinics, OIG inspectors observed that two nurses possessed keys to a narcotics locker during the same shift (MIT 7.101).

- The institution properly stored non-narcotic medications that require refrigeration at eight of the ten applicable clinics, receiving a score of 80 percent. One clinic refrigerator door lock was damaged and taped to prevent the door from locking. Another clinic refrigerator's temperature logs showed multiple entries documenting temperatures outside of the required ranges during a two-month period (MIT 7.103).

The institution has an opportunity to improve in the following area:

- Inspectors toured six medication areas and determined that half of them (50 percent) demonstrated appropriate administrative controls and protocols during medication distribution. At one pill line, there was no overhang or shade protection to shield patients from extreme weather elements. At two other pill lines, the nurse handed medication to the patient but could not visually observe that the patient ingested it because the nurse's line of

sight to the patient was obscured by dense window grids; custody did not assist the nurse in determining that the patient had swallowed the medication (MIT 7.106).

Pharmacy Protocols

This sub-indicator category consists of five questions, in which the institution received an average score of 98 percent, which falls 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 that required refrigeration and those that did not; and maintained adequate controls and properly accounted for narcotic medications. WSP scored 100 percent on each of these tests (MIT 7.107, 7.108, 7.109, 7.110).

- WSP followed key medication error reporting protocols in 18 out of 20 sampled instances (90 percent). The original Monthly Medication Error Statistic Report for October 2014 erroneously did not include any errors; it should have included one level 4 medication error. Also, a level 4 medication error that occurred in March 2015 was not timely reported. The incident was reported as an adverse sentinel event in May 2015, and was not reported as a medication error until June 2015 (MIT 7.111).

Non-Scored Tests

In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the institution properly identified and reported the errors. At WSP, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG tested inmate-patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. All sampled patients had access to their rescue medications (MIT 7.999).

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(77.2%)

Overall Rating:
Adequate

Compliance Testing Results

The institution received an *adequate* score of 77.2 percent in the *Preventive Services* indicator, scoring within the *proficient* or *adequate* range in the following four areas:

- Inspectors found that all 30 patients sampled were properly monitored while taking INH anti-tuberculosis medications (MIT 9.002).

- The institution was compliant in offering annual influenza vaccinations to 28 of 30 inmate-patients sampled (93 percent). Two inmate-patients neither received nor refused an influenza vaccination during the most recent influenza season (MIT 9.004).

- The OIG sampled 20 inmate-patients at high risk for contracting the coccidioidomycosis infection (valley fever) who were identified as medically restricted and ineligible to reside at WSP, to determine if the patients were transferred out of the institution within 60 days from the time they were determined ineligible. Inspectors found that WSP was compliant for 16 of the 20 inmate-patients sampled, scoring 80 percent. Four other inmate-patients were transferred out of the institution from 62 to 119 days after they had been identified as ineligible to reside there, meaning they were transferred out of WSP from 2 to 59 days late (MIT 9.009).

- The institution provided colorectal cancer screenings to 23 of 30 sampled inmate-patients subject to the annual screening requirement (77 percent). For four patients, there was no evidence of a colon cancer screening within the previous 12 months, even though a provider ordered one. For three other patients, there was no evidence that the patient was offered or refused the screening within the previous 12 months after having an abnormal colonoscopy (MIT 9.005).

The institution has opportunity for improvement in the following three areas:

- The OIG tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to inmate-patients who suffered from a chronic care condition; only 9 of the 19 patients sampled (47 percent) received or were offered all recommended vaccinations at the

required intervals. For ten patients, there was no evidence that the patients either received or refused one or more of the three types of vaccinations tested (MIT 9.008).

- OIG inspectors sampled 30 inmate-patients to test whether they received an annual tuberculosis screening within the last year. Fifteen of the sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check) and 15 were classified as Code 22 (requiring a tuberculosis skin test in addition to a signs and symptoms check). Although all 30 of the patients were screened for tuberculosis within the prior year, only 21 of them (70 percent) were properly tested. One patient's tuberculosis test was not read within the required 48-to-72-hour time frame. For four other patients, inspectors could not determine if the test results were timely read because staff failed to document the date and time the tuberculosis test was administered or read; for one of those four patients, the staff member who read the test also did not document his or her name and title. For three other patients, nursing staff did not complete the history evaluation section of the Tuberculin Testing/Evaluation Report (CDCR Form 7331); for the remaining patient, a psychiatric technician read the test results rather than an RN, public health nurse, or primary care provider (MIT 9.003).

- The institution scored 73 percent for timely administering anti-tuberculosis medications to patients with tuberculosis. Of 30 patients sampled, 22 received all required doses of their medication during the most recent three-month period. The eight remaining patients missed one or more doses of their medication and did not receive counseling for the missed medication (MIT 9.001).

Recommendations

No specific recommendations**.**

QUALITY OF NURSING PERFORMANCE

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

Case Review Results

The *Quality of Nursing Performance* at WSP was *adequate*. The OIG clinicians evaluated 198 nursing encounters and identified 49 deficiencies. There were only two significant deficiencies (cases 20 and 43).

Failure to Perform Providers' Orders

For three patients, WSP clinic nurses failed to perform providers' orders:

- In case 16, nurses did not implement an order for incentive spirometry and suture removal in one week, and nurses did not always perform daily wound care as ordered.
- In case 72, nurses did not check the patient's blood pressure on two of six days ordered.
- In case 77, nurses did not check the patient's blood pressure daily for five days and perform daily dressing changes as ordered.

Nursing Sick Call Triage Deficiencies

CCHCS policy requires the nurses to review all sick call requests on the same day they are received. The purpose of this review is to identify patients requiring same-day nursing assessment for serious complaints and symptoms, or to schedule the nursing assessment for the next business day as necessary.

- In case 7, the nurse reviewed a sick call request for complaints of fever, sore throat, cough, aching bones, and "the flu." The nurse failed to recognize the need to assess the patient the same day.

- In case 25, the nurse reviewed a sick call request for "stabbing" abdominal pain and painful urination, but did not assess the patient the same day.

- In case 43, the patient submitted a sick call request stating that he was recently discharged from a hospital, and the site on his arm from a recent intravenous access was red, hot, swollen, and painful. The nurse did not recognize the need to assess the patient the same day. The patient was at risk for a deep vein thrombosis (blood clot) or cellulitis (infection of the skin).

- In case 64, the nurse failed to assess the patient the same day for complaints of flu-like symptoms, including coughing, chest pain, and bone pain.

- In case 67, the nurse failed to assess the patient the same day for complaints of diarrhea, vomiting, and fever.

Nursing Assessment Deficiencies

The OIG clinicians reviewed documentation to determine if the nurse asked pertinent questions, performed necessary measurements, examined pertinent areas of the body, and noted the presence or absence of common accompanying signs and symptoms. Although most of the nursing assessments were generally *adequate*, the following cases demonstrated areas for nursing improvement:

- In case 19, the patient complained of dizziness with sudden movements or positional changes and that he did not "feel well." The patient had a history of stroke, diabetes, otitis media (middle ear infection), and hypertension (high blood pressure). The nurse did not check postural blood pressures and pulses, and did not document the presence or absence of neurological signs and symptoms.

- In case 20, the patient submitted a sick call request for flu-like symptoms, nosebleed, headaches, itchy skin, productive cough, and chronic pain in his left groin. The patient reported that he had stopped taking one of his medications. The patient had hepatitis C and

esophageal varices (enlarged blood vessels in the lower esophagus). The nurse did not assess the complaint of nosebleeds, did not document the presence or absence of usual signs and symptoms of gastrointestinal bleeding, and did not adequately assess the groin pain. The nurse also failed to document which medication the patient was not taking and failed to refer the patient to the provider.

- In case 59, the patient submitted a sick call request for coughing and inflammation in his lungs. The patient was receiving antibiotics, prednisone, and nebulizer treatments for a recent exacerbation of chronic obstructive pulmonary disease, but he stated that the medications were not helping. The nurse did not obtain peak flow measurements. The nurse noted that the patient had a provider visit scheduled in three weeks but should have referred him to the provider at an earlier date. The nurse also failed to refer the patient to the provider two months later when he again complained of respiratory symptoms.

- In case 60, the patient complained of blood in his stool and lesions on his body. The patient had a history of rectal cancer. The nurse checked vital signs and noted that the patient had a provider visit scheduled the next day. The nurse should have performed a focused assessment, even though the patient was scheduled to follow up with the provider the following day.

- In case 68, the patient submitted a sick call request for a rash. The nurse observed the rash and gave the patient hydrocortisone cream. The nurse did not document the patient's diagnosis of latent tuberculosis or that he was taking anti-tuberculosis medications that could cause a rash. The nurse did not report the rash to the provider for further evaluation.

Nursing Care Coordinators

Seven deficiencies were found related to care coordinator encounters or documentation. The OIG clinicians were aware that the nursing care coordinator program was not officially implemented at WSP until one month after the clinicians' onsite visit, and cited these deficiencies for quality improvement purposes only.

- In case 5, the patient reported that he was noncompliant with his KOP blood pressure medications. The nurse notified a provider, who did not give any orders. The nurse should have referred the patient to the provider to consider changing medications to "nurse-administered." In a different encounter, the nurse did not make a provider referral for the patient's elevated blood pressure.

- In case 16, the nurse did not check vital signs on a patient with hypertension.

- In case 18, the nurse signed a primary care nursing form, but much of the information on the form was incomplete and did not reflect the most recent scanned information.

- In case 20, the nurse failed to notify the provider of the patient's statement that he was noncompliant with his medications. Also, on two dates, the information on care coordinator follow-up review forms was incomplete or inaccurate.

Telemedicine

Most telemedicine nurses documented their notes on a form that had pre-printed information in the nursing "objective assessment" and "patient education" sections. Nurses failed to alter the pre-printed information when it did not apply to the specific patient, and did not adequately assess the patient for the medical condition being addressed by the telemedicine specialty provider. The following deficiencies were identified as opportunities for quality improvement:

- In case 16, the nurse used a pre-printed form. The pre-printed information in the "objective assessment" section stated the patient's pupils were equal and reactive to light. However, the patient's left cornea was opaque; therefore, the pupil was not visible. The nurse also failed to document detail regarding the specialty provider's plan of care for the patient.

- In case 17, the nurse used a pre-printed form. In the "subjective assessment" section, the nurse did not include the patient's report of occasional shortness of breath and failed to document the presence or absence of common symptoms of the patient's medical conditions. Also, the nurse did not document details of the specialty provider's plan of care; the nurse merely documented that the plan was reviewed.

- In case 19, the nurse used a pre-printed form indicating that the patient had no acute distress, but the patient had a heavy discharge from his ear.

- In case 25, the nurse used a pre-printed form on two encounters and did not include an assessment of the patient's fractured hand.

- In case 43, the nurse used a pre-printed form and did not include the presence or absence of significant symptoms of the patient's cardiac condition.

Medication Management and Administration

Outpatient medication administration was generally timely and reliable. During the onsite inspection visit, all the clinic and medication LVNs participated in the primary care morning huddles to ensure they shared medication issues and received pertinent information affecting the delivery of care. There were deficiencies identified, discussed in the *Pharmacy and Medication Management* indicator.

Emergency Care

Nursing emergency care and medical emergency first responders performed adequately, with the exception of one event. Documentation of the emergency events revealed adequate nursing decision-making and good performance during challenging cases. Most deficiencies were minor and unlikely to contribute to patient harm. The specific deficiencies are described in the *Emergency Services* indicator.

Clinician Onsite Inspection

During the onsite visit, the morning huddles started on time with good attendance. The clinic nurses were active participants in morning huddles and coordinated care to meet patients' needs. Custody and mental health staff attended the morning huddles only on an as-needed basis.

The OIG clinicians interviewed nursing staff from various clinical areas, including onsite and offsite specialty services, the reception center, the receiving and release area, telemedicine services, utilization management, the correctional treatment center, the triage and treatment area, yard clinics, the minimum yard clinic, and the administrative segregation unit. The nursing and supporting staff were knowledgeable about their duties, responsibilities, and patient populations within assigned clinical areas. Nursing had specific communication channels for making requests and reporting issues, and stated that they felt supported by their supervisors and the chief nurse executive. Nursing staff at all levels stated that there were no major barriers to communication with providers, nursing supervisors, or custody staff.

Recommendations

The OIG recommends that WSP initiate ongoing nursing education and monitoring of nurses' performance for sick call triage and telemedicine documentation.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 204 medical provider encounters and identified 94 deficiencies related to provider performance. Of those 95 deficiencies, 17 were significant. As a whole, WSP provider performance was *inadequate*.

Assessment and Decision-Making

The following seven significant deficiencies in provider encounters demonstrated inadequate assessment and unsound medical decision-making:

- In case 4, the patient had angina at rest (an unstable heart condition that can precede a heart attack) for two weeks. The provider did not elicit pain symptom location, intensity, or duration, nor any alleviating and aggravating factors. The provider should have obtained an electrocardiogram to evaluate for possible signs of acute myocardial ischemia or infarction (heart attack).

- Also in case 4, the patient had chest pain, and the recent cardiac stress test, which was positive for ischemia (inadequate blood supply to the heart), was not available for review. The provider should have contacted the specialty services department directly to obtain the report. The provider also failed to instruct the patient to alert medical staff for any further chest pain. Furthermore, instruction for follow-up in 21 days was too long for a patient with an unstable heart condition.

- In case 7, the patient was on amiodarone, a medication used for heart rate control. On a follow-up visit, the patient had marked bradycardia (abnormally slow heart rate) at 42 beats per minutes; the provider should have held amiodarone and closely monitored his heart rate.

- In case 25, the patient had two seizure episodes without any adjustment of his seizure medication. The provider should have ordered laboratory tests of levetiracetam (antiepileptic medication) levels, and if necessary, adjusted the medication.

- In case 29, the provider evaluated the patient regarding recent lab results, but did not address a critically high glucose level of 545 mg/dL and an acutely elevated creatinine of 1.41 mg/dL (showing worsening kidney function). These lab results indicated the patient had an unstable medical condition needing urgent treatment.

- In case 31, the patient had poorly controlled diabetes with a hemoglobin A1C of 8.8 percent (this lab test shows a three-month average blood sugar level of 206 mg/dL). The provider failed to adjust his basal insulin, and prescribed prednisone, which is not recommended for a poorly controlled diabetic patient as it could cause the blood sugar to rise quickly to unstable levels.

- In case 33, the provider made a diagnosis and referral for "acute black left fifth toe" without a progress note documenting physical examination and assessment. The provider should have provided a more complete assessment of this patient's gangrene in his foot, such as examining for infection and checking the circulation in the leg.

Emergency Care

Providers generally made appropriate triage decisions when patients presented emergently to the TTA, and generally were available for consultation with the TTA nursing staff. However, there were three significant deficiencies identified related to the quality of provider care in emergency services. The cases below are also discussed in the *Emergency Services* indicator:

- In case 5, the patient was recently discharged from hospitalization with a diagnosis of abdominal pain with possible gastritis (inflammation of the stomach). The provider had no clear working diagnosis for the abdominal pain, yet prescribed ketorolac and ibuprofen (nonsteroidal anti-inflammatory drugs). Both of these medications can make gastritis worse, and placed the patient at higher risk of stomach bleeding. The provider also failed to address a critically high blood pressure of 205/110 mmHg. Failure to recognize and treat high blood pressure placed this patient at risk of harm.

- In case 20, a provider evaluated the patient for lightheadedness with a heart rate of 40 beats per minute. The provider should have reviewed his current medications and held propranolol, a medication that slows the heart.

- In case 25, a provider was consulted for evaluation of an acute seizure. The provider failed to document a telephone consultation for this emergent event. The provider also failed to obtain a finger-stick blood sugar test to rule out low-blood-sugar-induced seizure. In addition, the provider failed to order lab tests to check the patient's levels of seizure medication and electrolytes.

Hospital Return

Because WSP providers did not properly sign several hospital discharge summaries, it was uncertain if the providers reviewed them and addressed all recommendations. This is highlighted in the following case that had three significant deficiencies in this area.

- In case 28, the providers failed to prescribe an antiarrhythmic medication as recommended by the hospitalist, placing the patient at significant risk of harm. As the patient returned from a recent hospitalization for paroxysmal atrial flutter with rapid ventricular response (irregular heart rhythm), a provider did not follow the hospital discharge recommendation to continue amiodarone for heart rate control. One month later, the patient was hospitalized for an episode of supraventricular tachycardia (rapid heart rate), and the hospitalist recommended continuing amiodarone; however, the provider did not prescribe the medication. Three months later, the patient had another episode of supraventricular tachycardia, and the provider, for the third time, failed to continue amiodarone as recommended by the hospitalist.

Chronic Care

WSP providers performed poorly in managing chronic medical conditions. In diabetic care, there were two significant deficiencies:

- In case 29, the patient's diabetes was well controlled with metformin. The provider inappropriately reduced the metformin dose by 50 percent without clearly indicating the reason. Subsequently, the patient had a severely elevated blood glucose level of 546 mg/dL, and a hemoglobin A1C of 12.3 percent (which is equivalent to a three-month blood sugar average of 322 mg/dL). The provider failed to recognize that the reduction of metformin contributed to this and placed the patient at risk of harm. The provider should have increased metformin or started insulin at this point.

- In case 31, during a period of five months, the patient had poorly controlled diabetes with hemoglobin A1Cs up to 9.3 percent (which is consistent with mean plasma glucose of 220 mg/dL). The provider did not adjust the patient's diabetic medications during these five months of poor control.

WSP providers performed poorly in managing hypertension, cardiovascular disease, and seizure disorder. There were three significant deficiencies:

- In case 4, the provider did not appropriately treat hypertension and an elevated cholesterol level in a diabetic patient with a history of smoking in order to lower the patient's cardiovascular risks. The patient also had chest pain. The provider did not prescribe sublingual nitroglycerin, nor instruct the patient to alert medical staff immediately with further episodes of chest pain.

- In case 25, the patient had a seizure disorder. The provider failed to recognize that topiramate, a seizure medication, had expired, which placed the patient at risk of seizures.

- In case 33, the patient had hypertension and was taking warfarin (blood thinner) for blood clots. The provider did not address an elevated blood pressure on four encounters. On one occasion, a provider failed to address an elevated blood pressure of 180/100 mmHg. The patient at that time had a laboratory test showing an excess level of warfarin. By not addressing the elevated blood pressure, the provider placed the patient at increased risk for a hypertensive cerebral bleed.

The following deficiencies were also identified in chronic care:

- In case 4, the patient had a calculated 16.2 percent ten-year risk of having a heart attack or stroke. At this level, a high-intensity cholesterol-lowering medication (statin) should have been prescribed. The provider did not assess the patient's risk for a cardiovascular event and did not prescribe an appropriate dose of a statin.

- In case 6, the patient arrived at WSP from a county jail with hypertension but no blood pressure medications. The provider did not address or treat the elevated blood pressure on two consecutive visits. On the day following the second visit, the patient was found unresponsive with an elevated blood pressure of 170/100 mmHg, and was transferred to a community hospital.

- In case 7, a provider prescribed gemfibrozil (medication to lower triglyceride blood fats) together with a statin. The Food and Drug Administration recommends against administering gemfibrozil along with a statin due to a significant risk of the side effect rhabdomyolysis (muscle breakdown and kidney injury).

- In case 20, the patient had esophageal varices (enlarged and fragile blood vessels in the esophagus); the provider ordered an increased propranolol dose to treat this condition. The increased dose was written "as tolerated," but the provider failed to provide parameters, such as keeping the resting heart rate at or greater than 55 beats per minute and systolic blood pressure greater than 90 mmHg. Subsequently, the patient developed lightheadedness with a low heart rate of 40 beats per minute.

- In case 20, a provider did not address a low platelet count of 67,000/microL. This count showed the patient had a risk of excessive bleeding.

- In case 30, the patient had poorly controlled diabetes with hemoglobin A1C of 9.7 percent (which is equivalent to a three-month blood sugar average of 231 mg/dL). The provider should have ordered a follow-up with the patient sooner than three months later to ensure proper management of diabetes.

- In case 35, this 62-year-old patient had diabetes, but the provider failed to start a statin, which placed the patient at risk for a heart attack.

Anticoagulation Management

WSP providers generally managed anticoagulation appropriately. There were two minor deficiencies:

- In case 27, the patient was taking warfarin for blood clots, and his laboratory tests showed an inadequate level of warfarin. However, the provider failed to increase the dose.

- In case 33, the provider did not hold warfarin for at least five days prior to the patient's surgical procedure.

Specialty Services

WSP providers generally referred appropriately and reviewed specialty reports timely; however, not all the reports were properly signed by the providers, and occasionally the providers failed to address all recommendations.

- In case 17, the provider reviewed the cardiology consultation with recommendations but did not order a magnesium level.

- In case 25, the provider did not address the orthopedic concern of osteopenia (low bone mineral density) by recommending that the patient avoid nonsteroidal anti-inflammatory drugs and soft drinks.

- In case 35, the provider did not address the podiatrist's assessment of peripheral vascular disease and lack of a pulse on the patient's right foot.

Health Information Management

The providers generally documented outpatient, TTA, and CTC encounters on the same day the patients were seen. Most progress notes were legible.

Clinician Onsite Inspection

At the time of the OIG inspection, there were two and one-half provider vacancies. Each provider was mainly assigned to one clinic to assure continuity of care. The chief physician and surgeon supervised the mid-level providers and performed annual evaluations for all the providers. The providers expressed dissatisfaction with specialty services, as many consultation reports were not retrieved or scanned into the eUHR. All providers attended the daily provider meeting and morning huddle. There was an afternoon sign-out meeting at which the providers informed the on-call physician of pending lab results and possible hospital returns on their respective yards.

Conclusion

The volume and severity of the deficiencies in provider performance, and the wide spectrum of deficiencies in emergency, reception center, hospital return, specialty services, and chronic care, led to an *inadequate* rating in the *Quality of Provider Performance* indicator.

Recommendations

No specific recommendations.

RECEPTION CENTER ARRIVALS

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(62.1%)

Overall Rating:
Inadequate

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.

Case Review Results

WSP had significant problems providing care to inmates arriving from county jails and other non-CDCR facilities. Nurses did not perform thorough assessments, and high-risk patients were not identified and seen urgently by a provider. Dialysis was not provided to a patient who subsequently required hospitalization, and one patient with multiple medical conditions was not seen by a provider for more than one month. Therefore, the *Reception Center Arrivals* indicator was rated *inadequate.* OIG clinicians reviewed 52 reception center patient encounters from 16 cases and identified 25 deficiencies; five of the deficiencies were significant:

- In case 13, the patient arrived at WSP and stated that he had had a seizure the day prior. The nurse failed to perform a subjective assessment of his seizure disorder and failed to obtain vital signs. After completing the assessment, the nurse should have consulted with a provider either by telephone or by sending the patient to the TTA. A complete physical and neurological exam should have been done to elicit any neurological deficits or signs of injuries from the seizure. Laboratory tests, such as phenytoin levels (seizure medication) and blood chemistries, should have been drawn to assess for the seizure activity cause. Five days later, the patient was found unresponsive in his cell, resuscitation was unsuccessful, and the patient died.

- In case 76, the patient arrived from another institution and did not receive hemodialysis as scheduled. Subsequently, the patient developed fluid overload and required hospitalization.

- In case 76, the patient arrived from another institution and did not receive his evening blood pressure medications. In addition, a nurse failed to recheck or assess for medication noncompliance for this patient with an elevated blood pressure of 171/94 mmHg. Subsequently, the patient developed dizziness and a blood pressure of 230/120 mmHg, which required hospitalization.

- In case 77, the patient, with diabetes, hypertension, hyperlipidemia, and coronary artery disease, arrived from another institution and was not seen timely by a provider for an intake history and physical. Screening blood tests were not done for over a month, and nursing staff failed to monitor daily blood pressure as the provider ordered.

The following minor deficiencies were also identified:

- In cases 6 and 78, nurses did not properly document the date and time of tuberculosis tests.

- In cases 6 and 35, the providers performed intake history and physical assessments, but did not address elevated blood pressures of 145/90 mmHg and 155/74 mmHg. The provider in case 6 also failed to address elevated blood pressures on the patient's two follow-up visits. Subsequently, the patient was found unresponsive with an elevated blood pressure of 170/100 mmHg and was transferred to a community hospital.

- In case 14, the initial provider visit did not occur within seven days as required.

- In cases 15, 75, 78, and 79, nurses did not perform complete evaluations, such as checking vital signs, measuring peak flows, or providing education and information to patients.

- In case 75, the nurse noted during an initial screening that the patient used a walker and that the patient was able to bear weight without the walker, but did not assess his ability to walk. Four days later, the provider noted residual symptoms from a stroke and ordered a wheelchair. Nurses in the yard clinic failed to follow up on the order until the patient submitted a sick call request two weeks later stating he had trouble getting around without the wheelchair.

Onsite Clinician Inspection

At the time of the onsite visit, reception center nursing exam areas lacked exam tables, proper lighting, and visual and auditory privacy. The OIG clinicians were informed that a larger, more private area was planned for construction in the near future. If a patient required a full physical examination, the patient would be sent to the TTA. The nurse on duty stated a provider was always readily available for orders and consultation.

Conclusion

Due to the serious deficiencies and failure of the yard clinic providers and nurses to follow up on findings from the nurses' initial health screening process, the OIG clinicians rated the *Reception Center Arrivals* indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 62.1 percent in the *Reception Center Arrivals* indicator. Although WSP scored well in four of the seven tests conducted, improvement is needed in three areas below that dropped the compliance score significantly.

- All 20 inmate-patients sampled who arrived at the WSP reception center were screened for tuberculosis tests, but each had his tuberculosis test read by either a licensed vocational nurse or by a psychiatric technician, instead of a register nurse, public health nurse, or primary care provider, as required by policy. As a result, WSP scored zero for this test. Also, in six instances, because staff did not document the time the test was administered, the OIG could not determine if the test was read within 72 hours (MIT 12.007).

- For intake tests ordered for reception center arrivals, the provider timely reviewed and communicated the test results for only 3 of the 20 inmate-patients sampled (15 percent). The provider reviewed one patient's test results seven days late; for two other patients, the provider communicated the test results to the patients 19 days late and over two months late. For 14 other patients, there was a lack of evidence in the eUHR that the provider timely reviewed the test results and timely communicated the results to the patient (MIT 12.006).

- The OIG also tested reception center arrivals to determine if they were offered the coccidioidomycosis (valley fever) skin test within 21 days of their arrival, and either refused the test or properly received it; 10 of the 20 sampled patients (50 percent) were timely offered, but refused the test. Eight of the ten other patients were offered the valley fever skin test from 5 to 66 days late; three of them refused the test and for the other five, there was no evidence in the eUHR of the date the test was administered and read. Similarly, there was no evidence in the eUHR of the date the test was administered and read for the two remaining patients who had been timely offered the test (MIT 12.008).

WSP scored within the *adequate* or *proficient* level in the four areas below:

- Providers timely evaluated 17 of the 20 sampled inmate-patients (85 percent), and timely completed a history and physical within seven calendar days of their arrival. For three patients, the history and physical was completed one to four days late (MIT 12.004).

- Providers also timely ordered intake tests for 17 of the 20 sampled patients (85 percent). For the other three patients, the provider ordered the applicable lab tests one to four days late (MIT 12.005).

- For all 20 patients, nursing staff timely completed the Initial Health Screening form (CDCR 7277) on the day the patient arrived at WSP's reception center, and timely completed the assessment and disposition section of the form (MIT 12.001, 12.002).

Recommendations

No specific recommendations.

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

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(76.0%)

Overall Rating:
Adequate

Case Review Results

At the time of the OIG visit, nine of the CTC's ten medical beds were occupied. Each bed was in an individual room. There were two negative pressure rooms (rooms designed to minimize spread of airborne infections). There were 37 provider encounters reviewed, with three deficiencies identified. There were 57 nursing events reviewed, with 35 deficiencies identified. The OIG clinicians rated the *Specialized Medical Housing* indicator *adequate.*

Provider Performance

The provider performance was adequate. The providers performed admission exams on all patients admitted to the CTC, and addressed all active medical conditions. The three provider deficiencies were minor and unlikely to contribute to patient harm:

- In case 7, the patient had a recent urological surgery; a provider admitted the patient to the CTC but did not obtain his vital signs.
- In case 21, on two occasions, the provider did not address the patient's elevated blood pressure.

Nursing Performance

In general, the nursing performance was adequate, but there were opportunities for improvement. There was failure to adequately assess and monitor decubitus ulcers (bedsores). Documents had an incomplete description of the wounds and dressing changes. Most reviewed nursing care plans were inadequate and were not individualized to the patient's needs. Nursing documentation was sometimes illegible, and cloned progress notes were found. Of the 36 deficiencies, 34 involved nursing performance and two involved medical records. One deficiency (case 11) contributed to patient harm, and other deficiencies reflected a minimal level of nursing involvement with individual patients.

- In case 11, the nursing care was inadequate. The patient had metastatic colon cancer and was losing weight due to poor oral intake. Nurses did not consistently document the patient's

intake and output and failed to weigh the patient three times a week as ordered. Nurses did not initiate care plans for the patient's chest tube, fall risk, confusion, and lower extremity edema. The nurse noted a decubitus ulcer but did not initiate a nursing care plan and notify the provider. Nurses did not perform follow-up assessments and treatment of the ulcer. Furthermore, the nurses did not always document administered medications, as the medication administration records of June and July 2015 showed several unfilled medication check boxes.

- In case 21, the patient had an open abdominal wound. The nurses did not consistently document the wound's color or drainage. The daily dressing changes were not performed as ordered. However, after surgical wound closure, the nurses did monitor the wound appropriately and perform dressing changes as ordered.

- In case 22, the patient had an incision and drainage of an abscess. The provider ordered dressing changes and an intravenous antibiotic. The nursing care plans were inadequate for the patient's condition, and nurses did not adequately address wound assessments, dressing changes, contact isolation, or care for a peripherally inserted central catheter.

- In case 80, a paraplegic (paralyzed legs) patient had multiple medical conditions requiring comprehensive nursing care and thorough documentation. Nursing notes were not always legible, and some were cloned. Nurses did not appropriately use soft ankle supports; subsequently, the patient developed heel decubitus ulcers (pressure sores). The initial nursing care plan for decubitus ulcers was reviewed monthly by the nurses; however, the care plan was not updated as new ulcers developed. The patient was transferred to another CDCR institution, and nurses did not provide a comprehensive nursing discharge note, thus hindering continuity of care.

- In case 84, the patient had a decubitus ulcer. Nurses' assessments of the decubitus ulcer were incomplete. A nurse noted a new open wound on the patient's right arm, but subsequent wound assessments were not done. The provider documented a healed ulcer, and nurses continued to document the presence of the ulcer. This documentation error was at least partially due to cloned nurses' notes.

Clinician Onsite Inspection

During the OIG's onsite visit, CTC nurses stated that they reviewed all patients each morning with the provider. Nursing care plans were maintained in a binder and were scanned when patients were discharged. The nurses reported having quick access to the patients' rooms and that custody was always available. Nurses received annual performance evaluations by their supervisors and were trained in new policies and procedures. The OIG clinicians asked one of the nurses to check the call light system in two rooms, but the nurse had difficulty demonstrating how the system worked. This was partially due to the location of the device in the nurses' station. The device was on an upper shelf and was too high for nurses to see the indicator lights or access the intercom telephone.

Compliance Testing Results

The institution received an *adequate* score of 76.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's correctional treatment center (CTC). WSP scored 100 percent in the following tests:

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

- Providers evaluated all ten sampled patients within 24 hours of admission and completed a history and physical within 72 hours of admission (MIT 13.002, 13.003).

WSP performed adequately in the following test:

- Providers completed their SOAPE notes at required three-day intervals for eight of the ten sampled patients (80 percent). For one patient, the provider did not complete the last required SOAPE note prior to the patient being discharged from the CTC; for another patient, the provider completed two SOAPE notes one and two days late (MIT 13.004).

The institution has an opportunity to improve in the following area:

- When the OIG observed the working order of a sample of call buttons in CTC patient rooms during their onsite visit in October 2015, inspectors found that the call buttons were not working. According to staff, a work order had been submitted for the broken call buttons. However, there were no interim measures in place, such as the use of a 30-minute welfare check log to confirm and document patient welfare. As a result, the institution received a score of zero for this test (MIT 13.101).

Recommendations

The OIG recommends that WSP implement the following actions:

- Evaluate the process in the CTC for monitoring nursing performance in the areas of decubitus ulcer and wound assessments, accurate and legible documentation, and individualized nursing care plans.

- Train nurses on WSP's current nursing care procedures regarding decubitus care. The SRN II should then monitor nurses' compliance with the requirements to ensure all care plans reflect current patient status and changes in treatment modalities.

- Move the placement of the CTC call light system device in the nurses' station so nurses can see the indicator lights and access the intercom telephone.

SPECIALTY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(74.0%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 169 events related to specialty services; there were 88 deficiencies, 12 of which were significant. The significant deficiencies related to retrieving or scanning the specialty reports into the eUHR and scheduling specialty appointments. The case review rating for the *Specialty Services indicator* was *inadequate*.

Provider Performance

Case review showed providers generally referred patients to specialists appropriately. The providers addressed specialist recommendations except on three occasions. These episodes are discussed further in the *Quality of Provider Performance* indicator.

Specialty Access

On three occasions, specialty services did not occur within the requested time frame, and on two occasions, specialty services did not occur at all:

- In case 5, a provider requested a stress echocardiogram (EKG) in preparation for a kidney transplant surgery, but a non-stress EKG was performed instead.
- In case 17, the patient had arrhythmia (an abnormal heart rhythm). The provider ordered an EKG, a nuclear myocardial perfusion scan, and a Holter monitor. The tests were performed, but almost one month later than requested.
- In case 33, a vascular surgeon removed a clotted arteriovenous graft, and recommended patient follow-up with the surgeon for suture removal in two weeks. The follow-up appointment did not occur, and there was no documentation that sutures were removed.
- In case 43, a provider requested an urgent general surgery consultation. The appointment occurred more than one month later than requested.

- In case 76, the patient arrived from another institution and did not receive hemodialysis as scheduled. Subsequently, the patient developed fluid overload and required hospitalization.

Health Information Management

The OIG identified 25 specialty reports that were not retrieved or scanned into the eUHR. On four occasions, the providers noted specialty reports were unavailable:

- In case 4, a provider evaluated the patient after an urgent cardiac stress test and documented "cardiac stress test not available for review." The patient was rescheduled for an appointment 21 days later.

- In case 17, a provider evaluated the patient after a cardiology appointment without the specialist's report. This required a rescheduled appointment the following week.

- In case 21, a provider evaluated the patient after a general surgery appointment and documented "no progress note available."

- In case 24, a provider evaluated the patient after a cardiology appointment and documented "no report available."

The OIG also identified 26 specialty reports not properly signed by the providers prior to scanning into the eUHR.

Clinician Onsite Inspection

At the time of the OIG inspection, WSP had dedicated staff assigned to specialty services; however, WSP lacked an effective tracking process to ensure specialty reports were retrieved and scanned into the eUHR.

Compliance Testing Results

The institution received an *inadequate* compliance score of 74.0 percent in the *Specialty Services* indicator. Although WSP scored in the *proficient* range for three of seven tests, it received *inadequate* scores for four other tests. The institution has room for improvement in the following areas:

- Providers timely reviewed specialists' reports for only 6 of 13 patients sampled (46 percent) who received a routine specialty service and 8 of 11 patients sampled (73 percent) who received a high-priority specialty service. For all ten of the remaining patients, there was no clear evidence on the Physician Request for Services (CDCR Form 7243), a progress note, or the consultant's report that the provider reviewed the report results (MIT 14.004, 14.002).

- Of the 17 patients sampled who had a specialty service denied, only nine patients (53 percent) received timely notification of the denied service, which included the provider meeting with the patient within 30 days of the denial to discuss alternate treatment strategies. For six patients, this requirement was not met at all; two other patients received a provider follow-up visit four and eight days late (MIT 14.007).

- When an inmate-patient is approved or scheduled for a specialty service appointment at one institution and then transfers to another institution, policy requires that the receiving institution ensure that the patient's appointment is timely rescheduled or scheduled, and held. Of seven sampled patients who transferred to WSP with an approved appointment, only five (71 percent) timely received their specialty services upon arrival. For two patients, there was no evidence that they received an appointment or that a provider had determined that the specialty service was no longer needed (MIT 14.005).

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

- The institution timely denied providers' specialty services requests for 19 of 20 patients sampled (95 percent). For one "urgent" specialty service request, the Medical Authorization Review committee denied the request six days late (MIT 14.006).

- For 14 of the 15 patients sampled (93 percent), their routine specialty service appointment or service occurred within 90 calendar days of the provider's order. One patient never received the specialty service ordered; instead, he received a different procedure that OIG clinicians determined was not medically equivalent (MIT 14.003).

- Thirteen of the 15 patients sampled (87 percent) received their high-priority specialty services appointment or service within 14 calendar days of the provider's order. One patient refused the service 17 days late; for another patient, the provider progress notes indicated the patient had refused the service, but there was no patient refusal form found in the eUHR (MIT 14.001).

Recommendations

No specific recommendations.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to WSP in October 2015. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

For comparative purposes, the *WSP Executive Summary Table* on page viii of this report shows the case review and compliance ratings for each applicable indicator.

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable

Compliance Score:
Proficient
(85.2%)

Overall Rating:
Proficient

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

Compliance Testing Results

WSP scored in the *proficient* range for the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a compliance score of 85.2 percent.

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

- WSP timely processed all inmate medical appeals in each of the most recent 12 months. Based on data received from the institution, there were no overdue medical appeals during the test period (MIT 15.001).

- Inspectors reviewed six recent months of QMC meeting minutes and confirmed that the QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified (MIT 15.003). Also, WSP took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

- WSP's local governing body (LGB) met quarterly during the most recent 12-month period; all meeting minutes provided a detailed narrative of the LGB's general management and planning of patient health care (MIT 15.006).

- The OIG inspected incident review packages for 12 emergency medical response incidents reviewed by the institution's EMRRC during the prior six-month period and found that all of them complied with policy (MIT 15.007).

- For all ten second-level medical appeals reviewed, the institution's response addressed all of the patients' appealed issues (MIT 15.102).

While the institution scored well in areas described above, the following three areas present an opportunity for improvement:

- WSP's 2014 Performance Improvement Work Plan did not adequately document that the institution had either improved performance or reached targeted performance objectives for two of its three main quality improvement initiatives, receiving a score of 33 percent (MIT 15.005).

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter and found that one of three drills did not include a completed Triage and Treatment Services Flowsheet (CDCR Form 7464), as required. As a result, WSP scored 67 percent (MIT 15.101).

- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for four of six inmate deaths that occurred at WSP during the OIG review period (67 percent). One death was reported approximately two hours late, and the other, only one hour late (MIT 15.103).

Other Information Obtained From Non-Scored Areas

- The OIG gathered non-scored data regarding death review reports and found that CCHCS's Death Review Committee did not timely complete its death review summary for four of the six deaths that occurred during the testing period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of an inmate-patient's death and submit it to the institution's CEO five business days later. However, the committee completed four summary reports between 5 and 35 days late (46 to 77 calendar days after the deaths). As a result, CCHCS did not timely submit those reports to the institution's CEO. For one other inmate death, the committee timely completed the death review summary, but submitted it to the CEO four days late (MIT 15.996).

- Inspectors met with the institution's chief executive officer (CEO) to inquire about WSP's protocols for tracking appeals. The health care appeals coordinator provided institution management with a monthly detailed trend analysis report and met monthly with the CEO to discuss all medical appeals reports. These included statistics on the appeals filed and their disposition; reports on the number of appeals that were filed, bypassed, canceled, denied, or granted during the month; overdue appeals; and the appealed issues listed by category. For WSP, the most frequent health care appeal subject areas were durable medical equipment (DME), staff allegations, medication, disagreement with treatment, medical forms, and access to care. Regarding DME, the institution recently received several complaints from wheelchair-bound inmates asking for gloves. After consideration, management determined that gloves should be a standard issue item for all wheelchair-bound inmates (MIT 15.997).

- Non-scored data regarding the institution's practices for implementing local operating procedures (LOPs) indicated that the institution had an effective process in place for revising existing LOPs and developing new ones. When new or revised policies and procedures were received from CCHCS, the Health Program Specialist (HPS) met with the source expert (usually the area supervisor) and developed recommendations for a new LOP or a revision to an existing LOP, as needed. The regional office, QMC, LGB, department head, and HPS then met, and the committee made final decisions about whether a new or revised LOP was needed and what areas should be covered. Once the LOP was approved and completed, it was placed on the shared drive and emailed to area supervisors. It was the area supervisors' responsibility to disseminate the policy to staff. At the time of the OIG's inspection in October 2015, WSP had implemented 46 of the 48 applicable stakeholder-recommended LOPs (96 percent) (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

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(100.0%)

Overall Rating:
Proficient

Compliance Testing Results

The institution received a *proficient* compliance score of 100 percent in the *Job Performance, Training, Licensing, and Certifications* indicator.

WSP scored 100 percent for each of the eight tests, as follows:

- All providers, nursing staff, and the pharmacist-in-charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).
- Nursing supervisors completed the required number of nursing reviews for all five of the nurses the OIG sampled (MIT 16.101).
- All ten nurses sampled were current on their clinical competency validations (MIT 16.102).
- All providers received timely and complete annual performance appraisals, including applicable Unit Health Record Clinical Appraisals, PCP—360 Degree Evaluations, and Core Competency-Based Evaluations (MIT 16.103).
- All provider, nursing, and custody staff had current emergency response certifications (MIT 16.104).
- The institution's pharmacy and providers who prescribed controlled substances were current with their Drug Enforcement Agency registrations (MIT 16.106).
- All nursing staff hired within the last year timely received new employee orientation training (MIT 16.107).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

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

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. While WSP either outperformed or performed similarly to other entities in four of the five diabetic measures selected, it performed much more poorly than other entities in conducting required dilated eye exams for diabetic patients.

When compared statewide, WSP significantly outperformed Medi-Cal in four of the five measures (diabetic monitoring, diabetics under poor control, diabetics under good control, and blood pressure control). When compared to Kaiser Permanente, WSP outperformed Kaiser in diabetic monitoring and diabetics under poor control, but did not perform quite as well as Kaiser with respect to both diabetics under good control and diabetic patient blood pressure control. The institution scored lower than both Medi-Cal and Kaiser in conducting eye exams for diabetic patients.

When compared nationally, WSP outperformed or closely matched Medicaid, Medicare, commercial health plans (based on data obtained from health maintenance organizations), and the U.S. Department of Veterans Affairs (VA) in all diabetic measures except eye exams. In fact, WSP scored 58 percentage points lower than the VA in conducting dilated eye exams for its diabetic patients.

Immunizations

Comparative data for influenza immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, and Medicare. With respect to these measures, WSP performed significantly more poorly than all of those entities. However, in addition to the patients who actually received the immunization, many others were offered the vaccination but refused it, negatively affecting the institution's scores in this metric.

For the administration of pneumococcal vaccines to older adults, WSP performed better than Medicare, but not as well as the VA.

Cancer Screening

For colorectal cancer screenings provided to older adults, WSP's score was slightly lower than the Kaiser scores for both Northern and Southern California. When compared nationally, WSP performed slightly less than the VA but significantly better than both commercial plans and Medicare. Again, patient refusals impacted the institution's performance in this measure; an additional six patients (15 percent of the 40 patients sampled) were timely offered the screening but refused it.

Summary

Overall, WSP's performance reflects an adequate chronic care program, corroborated by the institution's *adequate* rating in the *Preventive Services* indicator, and its *proficient* rating in the *Access to Care* indicator. The institution has an opportunity for improvement in timely conducting dilated eye exams for its diabetic patients and lowering patient refusals for influenza immunizations and colorectal cancer screenings.

WSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	WSP Cycle 4 Results [1]	HEDIS Medi-Cal 2014 [2]	Kaiser (No.CA) HEDIS Scores 2015 [3]	Kaiser (So.CA) HEDIS Scores 2015 [3]	HEDIS Medicaid 2015 [4]	HEDIS Com-mercial 2015 [4]	HEDIS Medicare 2015 [4]	VA Average 2012 [5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) [6,7]	**14%**	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**62%**	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90) [6]	**79%**	60%	84%	85%	62%	65%	65%	80%
Eye Exams	**32%**	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64) [8]	**35%**	-	54%	55%	-	50%	-	65%
Influenza Shots - Adults (65+)	**60%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**80%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**78%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in October 2015 by reviewing medical records from a sample of WSP's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.
2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services 2014 *HEDIS Aggregate Report for the Medi-Cal Managed Care Program*.
3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.
5. The Department of Veterans Affairs (VA) data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.
6. For this indicator, the entire applicable WSP population was tested.
7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.
8. The HEDIS VA data is for the age range 50–64.

APPENDIX A — COMPLIANCE TEST RESULTS

Wasco State Prison Range of Summary Scores: 59.85% - 100.00%	
Indicator	**Compliance Score (Yes %)**
Access to Care	88.24%
Diagnostic Services	59.85%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	74.11%
Health Care Environment	81.67%
Inter- and Intra-System Transfers	75.09%
Pharmacy and Medication Management	87.82%
Prenatal and Post-delivery Services	Not Applicable
Preventive Services	77.24%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	62.14%
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	76.00%
Specialty Services	74.04%
Internal Monitoring, Quality Improvement, and Administrative Operations	85.19%
Job Performance, Training, Licensing, and Certifications	100.00%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	28	2	30	93.33%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	15	6	21	71.43%	4
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	34	1	35	97.14%	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?	35	0	35	100.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	8	2	10	80.00%	25
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?	6	1	7	85.71%	28
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	25	2	27	92.59%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	17	6	23	73.91%	7
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall Percentage:					**88.24%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	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	100.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	5	5	10	50.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	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?	1	8	9	11.11%	1
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	7	1	8	87.50%	2
Overall Percentage:					**59.85%**	

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

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	20	0	20	100.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	4	1	5	80.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	17	3	20	85.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	20	0	20	100.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	15	0	15	100.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	23	17	40	57.50%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	19	8	27	70.37%	0
Overall Percentage:					**74.11%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	10	2	12	83.33%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	12	0	12	100.00%	0
5.103	**Infection control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	10	2	12	83.33%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	10	2	12	83.33%	0
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	7	5	12	58.33%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	12	0	12	100.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	9	3	12	75.00%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	10	2	12	83.33%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	5	7	12	41.67%	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?	9	1	10	90.00%	2
5.999	**For informational purposes only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall Percentage:					**81.67%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	24	1	25	96.00%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	25	0	25	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	7	2	9	77.78%	16
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	7	13	20	35.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	2	1	3	66.67%	7
Overall Percentage:					**75.09%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	14	1	15	93.33%	15
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	29	1	30	96.67%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	16	11	27	59.26%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	6	1	7	85.71%	13
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	25	5	30	83.33%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	7	3	10	70.00%	0
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	11	2	13	84.62%	5
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?	16	0	16	100.00%	2
7.103	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	8	2	10	80.00%	8
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?	6	0	6	100.00%	12
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	6	0	6	100.00%	12
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	3	3	6	50.00%	12
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	18	2	20	90.00%	0
7.998	**For informational purposes only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For informational purposes only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall Percentage:					**87.82%**	

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

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed INH:** Did the institution administer the medication to the inmate-patient as prescribed?	22	8	30	73.33%	0
9.002	**Inmate-patients prescribed INH:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	30	0	30	100.00%	0
9.003	**Annual TB screening:** Was the inmate-patient screened for TB within the last year?	21	9	30	70.00%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	28	2	30	93.33%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	23	7	30	76.67%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	9	10	19	47.37%	11
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	16	4	20	80.00%	0
Overall Percentage:					**77.24%**	

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

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

Reference Number	*Reception Center Arrivals*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
12.001	**For inmate-patients received from a county jail:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	20	0	20	100.00%	0
12.002	**For inmate-patients received from a county jail:** When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening?	20	0	20	100.00%	0
12.003	**For inmate-patients received from a county jail:** If, during the assessment, the nurse referred the inmate-patient to a provider, was the inmate-patient seen within the required time frame?	Not Applicable				20
12.004	**For inmate-patients received from a county jail:** Did the inmate-patient receive a history and physical by a primary care provider within seven calendar days?	17	3	20	85.00%	0
12.005	**For inmate-patients received from a county jail:** Were all required intake tests completed within specified timelines?	17	3	20	85.00%	0
12.006	**For inmate-patients received from a county jail:** Did the primary care provider review and communicate the intake test results to the inmate-patient within specified timelines?	3	17	20	15.00%	0
12.007	**For inmate-patients received from a county jail:** Was a tuberculin test both administered and read timely?	0	20	20	0.00%	0
12.008	**For inmate-patients received from a county jail:** Was a Coccidioidomycosis (Valley Fever) skin test offered, administered and read timely?	10	10	20	50.00%	0
Overall Percentage:					**62.14%**	

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	10	0	10	100.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	10	0	10	100.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	8	2	10	80.00%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	0	1	1	0.00%	0
Overall Percentage:					**76.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	13	2	15	86.67%	0
14.002	Did the PCP review the high-priority specialty service consultant report within the required time frame?	8	3	11	72.73%	4
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	14	1	15	93.33%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	6	7	13	46.15%	2
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	5	2	7	71.43%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	19	1	20	95.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	9	8	17	52.94%	3
Overall Percentage:					**74.04%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	1	2	3	33.33%	1
15.006	**For institutions with licensed care facilities:** Does the local governing body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	4	0	4	100.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	2	1	3	66.67%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	4	2	6	66.67%	0
15.996	**For informational purposes only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For informational purposes only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For informational purposes only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For informational purposes only:** Identify the institution's health care staffing resources.	Information Only				
Overall Percentage:					**85.19%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	14	0	14	100.00%	0
16.101	Does the institution's supervising registered nurse conduct periodic reviews of nursing staff?	5	0	5	100.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	13	0	13	100.00%	0
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	0
16.105	Are nursing staff and the pharmacist-in-charge current with their professional licenses and certifications?	4	0	4	100.00%	2
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	3
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall Percentage:					**100.00%**	

APPENDIX B — CLINICAL DATA

Table B-1: WSP Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	2
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services - CPR	2
Emergency Services - Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers in	3
Intra-System Transfers out	3
RN Sick Call	35
Reception Center Transfers	5
Specialty Services	5
	81

Table B-2: WSP Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	9
Anticoagulation	5
Arthritis/Degenerative Joint Disease	2
Asthma	11
COPD	8
Cancer	3
Cardiovascular Disease	8
Chronic Kidney Disease	14
Chronic Pain	17
Cirrhosis/End Stage Liver Disease	2
Coccidioidomycosis	2
Deep Venous Thrombosis/Pulmonary Embolism	4
Diabetes	17
Diagnosis	2
Gastroesophageal Reflux Disease	8
Gastrointestinal Bleed	1
Hepatitis C	26
Hyperlipidemia	23
Hypertension	42
Mental Health	8
Seizure Disorder	4
Sleep Apnea	2
Thyroid Disease	1
	219

Table B-3: WSP Event/Program	
Program	**Total**
Diagnostic Services	220
Emergency Care	54
Hospitalization	60
Intra-System Transfers in	12
Intra-System Transfers out	17
Outpatient Care	445
Reception Center Care	51
Specialized Medical Housing	106
Specialty Services	160
	1,125

Table B-4: WSP Case Review Sample Summary	
	Total
MD Reviews, Detailed	31
MD Reviews, Focused	4
RN Reviews, Detailed	22
RN Reviews, Focused	44
Total Reviews	101
Total Unique Cases	81
Overlapping Reviews (MD & RN)	20

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Wasco State Prison			
Quality Indicator	**Sample Category (number of patients/samples)**	**Data Source**	**Filters**
Access to Care	Chronic Care (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
	Nursing Sick Call (5 per clinic) (35)	MedSATS	• Clinic (each clinic tested) • Appt. date (2–9 months) • **Randomize**
	Returns from Community Hospital (27)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
Diagnostic Services	Radiology (10)	Radiology Logs	• Appt. Date (90 days–9 months) • **Randomize** • Abnormal
	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**
Health Information Management (Medical Records)	Timely Scanning (20)	OIG Qs: 1.001, 1.002, 1.004	• Non-dictated documents • First 5 inmate-patients selected for each question
	(5)	OIG Q: 1.001	• Dictated documents • First 20 inmate-patients selected
	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 inmate-patients selected for each question
	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 inmate-patients selected for the question
	(15)	OIG Q: 7.001	• MARs • First 20 inmate-patients selected
	Legible Signatures and Review (40)	OIG Qs: 4.008, 6.001/6.002, 7.001, 12.001/12.002, & 14.002	• First 8 inmates sampled • One source document per inmate-patient
	Complete and Accurate Scanning	Documents for any tested inmate	• Any incorrectly scanned eUHR document identified during OIG eUHR file review, e.g., mislabeled, misfiled, illegibly scanned, or missing
	Returns from Community Hospital (27)	Inpatient Claims Data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Health Care Environment	Clinical Areas (12)	OIG Inspector Onsite Review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers	Intra-System transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
	Specialty Service Send-outs (20)	MedSATS	• Date of Transfer (3–9 months) • **Randomize**
Pharmacy and Medication Management	Chronic Care Medication (15)	OIG Q: 1.001	See ***Access to Care*** • (At least one condition per inmate-patient—any risk level) • **Randomize**
	New Medication Orders (30—Basic Level)	Master Registry	• Rx Count • **Randomize** • Ensure no duplication of inmate-patients tested in chronic care medications
	Intra-Facility moves (30)	MAPIP Transfer Data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (high–low)–*inmate-patient must have NA/DOT meds to qualify for testing* • **Randomize**
	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • Length of stay (minimum of 2 days) • NA/DOT meds
	Returns from Community Hospital (30)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
	Medication Preparation and Administration Areas	OIG Inspector Onsite Review	• Identify and inspect onsite clinical areas that prepare and administer medications
	Pharmacy	OIG Inspector Onsite Review	• Identify and inspect onsite pharmacies
	Medication Error Reporting (20)	OIG Inspector Onsite Review	• Five reports from five months with high-severity errors (if applicable)
Prenatal and Post-Delivery Services	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Preventive Services	Chronic Care Vaccinations (19)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per inmate-patient—any risk level) • **Randomize** • Condition must require vaccination(s)
	INH (30)	Maxor	• Dispense date (past 9 months) • Time period on INH (at least a full 3 months) • **Randomize**
	Colorectal Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out inmate-patients tested in chronic care vaccination sample
	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 years prior to inspection) • Date of birth (age 52–74) • **Randomize**
	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three years prior to inspection) • Date of birth (age 24–53) • **Randomize**
	Valley Fever (20)	Cocci Transfer Status Report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**
Reception Center Arrivals	RC (20)	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing	CTC (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Specialty Services Access	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
	Specialty Service Arrivals (7)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
	Denials (20)* **Ten InterQual* *Ten MARs*	InterQual	• Review date (3–9 months) • **Randomize**
		IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**
Internal Monitoring, Quality Improvement, and Administrative Operations	Medical Appeals (all)	Monthly Medical Appeals Reports	• Medical appeals (12 months)
	Adverse/Sentinel Events *N/A at this institution*	Adverse/Sentinel Events Report	• Adverse/sentinel events (2–8 months)
	QMC Meetings (6)	Quality Management Committee Meeting Minutes	• Monthly meeting minutes (6 months)
	Performance Improvement Plans (3)	Performance Improvement Work Plan	• Performance Improvement Work Plan with updates (12 months) • Medical Initiatives
	Local Governing Body (4)	Local Governing Body Meeting Minutes	• Quarterly meeting minutes (12 months)
	EMRRC (12)	EMRRC Meeting Minutes	• Monthly meeting minutes (6 months) • Two incidents
	Medical Emergency Response Drills (3)	OIG Inspector Onsite Review	• Most recent full quarter • Each watch
	2nd Level Medical Appeals (10)	OIG Inspector Onsite Review	• Medical appeals denied (6 months)
	Death Reports (6)	OIG Inspector Onsite Review	• Death reports (12 months)
	Local Operating Procedures (all)	OIG Inspector Onsite Review	• All LOPs • Select five samples for testing

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications	RN Review Evaluations (5)	OIG Inspector Onsite Review	• Current Supervising RN reviews
	Nursing Staff Validations (10)	OIG Inspector Onsite Review	• Review annual competency validations • **Randomize**
	Provider Annual Evaluation Packets (13)	OIG Inspector Onsite Review	• All required performance evaluation documents
	Medical Emergency Response Certifications (all)	OIG Inspector Onsite Review	• All staff o Providers (ACLS) o Nursing (BLS/CPR) o Custody (CPR/BLS)
	Nursing staff and Pharmacist-in-charge Professional Licenses and Certifications (all)	OIG Inspector Onsite Review	• All licenses and certifications
	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	OIG Inspector Onsite Review	• All current DEA registrations
	Nursing Staff New Employee Orientations (all)	OIG Inspector Onsite Review	• New employees (within the last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

April 11, 2016

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Wasco State Prison (WSP) conducted from October 2015 to December 2015. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

for

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
Jared Goldman, Counsel to the Receiver
Roy Wesley, Chief Deputy Inspector General, OIG
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