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Office of the Inspector General

Wasco State Prison
Medical Inspection Results
Cycle 5

August 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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Cycle 5

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EXECUTIVE SUMMARY

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards. In Cycle 5, for the first time, the OIG will be inspecting institutions that have been delegated back to CDCR from the Receivership. There will be no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated.

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.

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

Overall Assessment: Adequate

The OIG performed its Cycle 5 medical inspection at Wasco State Prison (WSP) from February to April 2017. The inspection included in-depth reviews of 54 patient files conducted by clinicians, as well as reviews of documents from 456 patient files, covering 99 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 14 health care quality indicators applicable to the institution. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of registered nurses trained in monitoring medical policy compliance. Of the indicators, eight were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *WSP Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

WSP Executive Summary Table

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

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 762 patient care events.[1] Of the 13 indicators applicable to WSP, 11 were evaluated by clinician case review; 10 were *adequate* and one was *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 leadership had improved operations since the OIG's Cycle 4 inspection. Managers stated that they targeted areas from the OIG's Cycle 4 inspection report for quality improvement. These included the *Reception Center Arrivals*, *Health Information Management*, and *Specialty Services* indicators. Improvement was evident with case review ratings going from *inadequate* to *adequate* from Cycle 4 to Cycle 5.

- WSP was able to effectively manage the demands of a high number of health care encounters in their Reception Center by effective health care team communication. This was facilitated by their well-attended and effective huddles, as well as other meetings.

- The physicians had good morale, and felt supported by the leadership at WSP. There were no vacancies at the time of the inspection.

- The nurse management team worked well together, and nursing staff in all clinical areas had good morale. Nurses working in positions such as telemedicine, public health, tuberculosis (TB) control, utilization management, and specialty services scheduling had additional cross-trained nursing staff to cover as needed.

Program Weaknesses — Clinical

- While the OIG found the *Quality of Provider Performance* adequate, there was still room for improvement. Two patients in the correctional treatment center (CTC) received inadequate care, with many significant deficiencies. These issues contributed to the *Specialized Medical Housing* indicator in this report to be rated *inadequate.*

- In contrast to the good morale of the WSP physicians, the mid-level providers expressed dissatisfaction with their positions. This centered on a lack of salary adjustment for many

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

years. The mid-level providers stated that this would likely lead to some of them leaving state service to return to the community.

- The *Diagnostics Services* indicator, while rated adequate, had multiple deficiencies related to failure to retrieve and scan radiology reports into the electronic health record. This failure to place the reports into the electronic medical records was in keeping with CCHCS policy, which was not to scan into the electronic health record, but instead to leave the reports only in the separate repository for radiology reports. Only the additional work and diligence of the WSP providers kept this indicator from an *inadequate* rating. The providers needed to spend time searching another report repository for this information to ensure appropriate patient care was given. However, some events were found when the information was not retrieved, and the providers were unaware of important radiology findings.

- Although the *Emergency Services* indicator was rated *adequate*, the licensed vocational nurses and psychiatric technicians who serve as first medical responders would benefit by additional education and training on oxygen administration. All nursing staff involved in medical emergency responses would benefit by additional training for documentation of emergency medical events using sequential, timed entries rather than summarized entries.

Compliance Testing Results

Of the 14 health care indicators applicable to WSP, 11 were evaluated by compliance inspectors.[2] Two were *proficient*, four were *adequate*, and five were *inadequate*. There were 99 individual compliance questions within those 11 indicators, generating 1,368 data points that tested WSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 99 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- Nursing staff reviewed sick call requests and completed face-to-face encounters within required time frames. In addition, all housing units inspected had health care request forms available for patients.

- The institution provided timely laboratory services to patients, and providers reviewed and communicated laboratory results to patients within required time frames.

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

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

- Upon patient transfers to WSP from other CDCR institutions, nursing staff properly completed the Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived, and completed the assessment and disposition sections of the form.

- Patients that transferred to WSP from a county jail received a timely initial health screening, and nursing staff appropriately completed and signed the health screening form. In addition, reception center patients received all required laboratory tests, and providers reviewed and communicated the results to patients within required time frames.

- Patients received their high-priority and routine specialty service appointments timely, and providers reviewed the specialty service reports within required time frames.

Program Weaknesses — Compliance

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

- The institution did not always provide pathology services timely, and providers did not always communicate pathology results to patients as required by CCHCS policy.

- Scanning accuracy of patient documents into the electronic health record was poor.

- Several clinic locations at WSP did not properly mitigate exposure to blood borne pathogens and contaminated waste because exam rooms lacked sharps containers, and not all clinic locations had essential supplies available to staff.

- Several medication line locations at WSP did not follow proper security controls over narcotic medications, and several locations also did not properly store non-narcotic medications that did not require refrigeration.

- The institution did not always monitor patients on TB medications as required. In addition, for those patients sampled for annual TB screening, inspectors found nursing staff did not always properly document their signs and symptoms or history of TB.

- Nursing supervisors did not properly document their reviews of subordinate staff.

Population-Based Metrics

In general, WSP performed very well as measured by population-based metrics. In comprehensive diabetes care, WSP outperformed other State and national organizations in most measures.

With regard to immunization measures, WSP's comparative scores were mixed. However, WSP's rates for colorectal cancer screening were higher than those of all other reporting entities. Overall, WSP's performance demonstrated by the population-based metrics indicated that the chronic care program was well run and functioning properly.

Recommendations

The OIG recommends the institution develop a process to improve access to all radiology reports that have not been scanned into the eUHR since late 2015.

The OIG recommends WSP leadership provide training for providers on spending adequate time reviewing the medical records of unfamiliar patients, even when caring for the patient for a brief time. This is especially important for the more complex patients in the CTC.

INTRODUCTION

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

Wasco State Prison (WSP) was the fourth medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The Administrative Operations indicator is purely administrative and is not reflective of the actual clinical care provided.

ABOUT THE INSTITUTION

Wasco State Prison (WSP) is one of two CDCR reception centers located in Kern County. As a reception center, the primary mission of WSP is to provide short-term housing necessary to process, classify, and evaluate incoming inmates from county jails to determine their security level, program requirements, and appropriate institutional placement. The institution runs multiple clinics where medical staff handles non-urgent requests for health care services. WSP also treats patients requiring urgent or emergency care in its triage and treatment area (TTA), and treats patients requiring inpatient health services in its 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 patient population.

WSP received accreditation from the Commission on Accreditation for Corrections on March 20, 2017. This nationally recognized accreditation program is a professional peer review process based on standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, WSP's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 20 percent in January 2017, with the highest vacancy percentages among nursing staff at 23 percent. At the time of the OIG's inspection, three nursing staff members were on long-term medical leave.

WSP Health Care Staffing Resources as of January, 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	4	2%	12.5	6%	13.6	7%	162.8	84%	192.9	100%
Filled Positions	4	100%	12.5	100%	11.6	85%	126	77%	154.1	80%
Vacancies	0	0%	0	0%	2	15%	36.8	23%	38.8	20%
Recent Hires (within 12 months)	1	25%	4.5	36%	4	34%	44	35%	53.5	35%
Staff Utilized from Registry	0	0%	1	8%	0	0%	29	23%	30	19%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	1	9%	0	0%	1	1%
Staff on Long-term Medical Leave	0	0%	0	0%	0	0%	3	2%	3	2%

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

As of January 30, 2017, the Master Registry for WSP showed that the institution had a total population of 4,953. Within that total population, 1.2 percent were designated as high medical risk, Priority 1 (High 1), and 2.9 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

WSP Master Registry Data as of January 30, 2017

Medical Risk Level	# of Patients	Percentage
High 1	61	1.2%
High 2	146	2.9%
Medium	1,755	35.4%
Low	2,991	60.4%
Total	**4,953**	**100.0%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

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

CASE REVIEWS

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

Patient Selection for Retrospective Case Reviews

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

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

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

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

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

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

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

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

Benefits and Limitations of Targeted Subpopulation Review

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

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

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

Case Reviews Sampled

As indicated in *Appendix B, Table B–1: WSP Sample Sets,* the OIG clinicians evaluated medical charts for 54 unique patients. *Appendix B, Table B–4: WSP Case Review Sample Summary,* clarifies that both nurses and physicians reviewed charts for 7 of those patients, for 61 reviews in total. Physicians performed detailed reviews of 20 charts, and nurses performed detailed reviews of 7

charts, totaling 27 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 34 patients. These generated 762 clinical events for review (*Appendix B, Table B–3: WSP Event-Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only 6 chronic care patient records, i.e., 3 diabetes patients and 3 anticoagulation patients (*Appendix B, Table B–1: WSP Sample Sets*), the 54 unique patients sampled included patients with 181 chronic care diagnoses, including 12 additional patients with diabetes (for a total of 15) and one additional anticoagulation patient (for a total of 4) (*Appendix B, Table B–2: WSP Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy.

The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation". The OIG found the Cycle 4 medical inspection physician sample size of 30 detailed reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were re-analyzed using 50 percent of the cases, finding no significant differences in the ratings. To improve inspection efficiency, while preserving the quality of the inspection, the samples for Cycle 5 medical inspections were reduced in number of cases. For Cycle 5 inspections, basic institutions, with low high-risk populations, case review will use 67 percent of the case review samples used in Cycle 4 inspection, for both physician and nurse reviewed cases (20 detailed reviews). For intermediate institutions, or basic institutions housing many high-risk patients, the case review samples will use 83 percent (25 detailed reviews). Finally, the most medically complex institution, CHCF, has retained the full 100 percent samples of Cycle 4 inspections.

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

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate

confidential *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 February to April 2017, registered nurse inspectors attained answers to 99 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 456 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of February 13, 2017, field registered nurse 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 1,368 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 cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators; *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications,* and have combined these tests into one *Administrative Operations* indicator for cycle 5 inspections.

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

Scoring of Compliance Testing Results

After compiling the answers to the 99 questions for the 11 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those

results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

The OIG identified a subset of Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR patient population. To identify outcomes for WSP, the OIG reviewed some of the compliance testing results, randomly sampled additional 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

The quality indicators assess the clinical aspects of health care. As shown on the *WSP Executive Summary Table* on page *ii* of this report, 14 of the OIG's indicators were applicable to WSP. Of those 14 indicators, 8 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 3 were rated by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied upon for the overall score for the institution. Based on the analysis and results in the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at WSP was ***adequate***.

Summary of Case Review Results: The clinical case review component assessed 11 of the indicators applicable to WSP; OIG clinicians rated none *proficient*, ten *adequate*, and one *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, one was *proficient*, 13 were *adequate*, and 6 were *inadequate*. In the 764 events reviewed, there were 171 deficiencies, of which 64 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review: Adverse Events are medical errors which cause serious patient harm. 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 were three adverse events identified in the case reviews at WSP, as follows:

- In case 1, there was a critically ill patient with dangerously low blood pressure. The transfer to the TTA, as well as transport to the hospital, was delayed by two hours. The patient eventually died, from an accidental overdose of blood pressure medication. While it was unlikely the death was preventable, WSP's severely delayed emergency response worsened the patient's chance of survival.

- In case 8, the provider placed a patient at risk by having the patient undergo an elective surgery for back pain. The patient had a recent blood clot, and was placed at risk by temporarily stopping the blood thinning medication to allow the surgery. Fortunately, no harm came to the patient.

- In case 9, the provider failed to change a seizure medication that was likely causing liver inflammation after the patient was hospitalized. The hospital physician who had cared for the patient had advised the change in the discharge report.

Summary of Compliance Results: The compliance component assessed 11 of the 14 indicators applicable to WSP. Of these 11 indicators, OIG inspectors rated two *proficient*, four *adequate*, and five *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

1 — *ACCESS TO CARE*

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(84.6%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 278 provider and nurse encounters relating to access to care, and identified 16 deficiencies 7 of which were significant. WSP, with regard to the *Access to Care* indicator, was rated *adequate*.

Provider-to-Provider Follow-up Appointments

Three deficiencies consisted of provider-to-provider appointments that were delayed or missed. Two of these were significant:

- In case 9, the provider-requested three-day follow-up for a patient with acute hepatitis did not occur. However, the patient did see an infectious disease specialist one month later.
- In case 19, the provider-requested one-week follow-up for a patient with valley fever was delayed for two months.

RN Sick Call Access

The institution performed well for RN appointments related to sick call. The OIG identified only one minor appointment and scheduling deficiency in this area.

RN-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. WSP did well for most of these referrals. The OIG identified only two minor deficiencies in cases 7 and 9.

RN Follow-up Appointments

The institution performed well with scheduling and completing RN appointments that were generated by WSP clinicians. The OIG found no deficiencies.

Intra-System Transfers and Reception Center

WSP did well with appointments and scheduling for patients transferring from other prisons or into the reception center. This was remarkable for an institution with nearly 5,000 patients. According to WSP leadership, the institution conducts approximately 15,000 health care appointments per month for medical, dental, mental health, or diagnostic services.

Follow-up After Hospitalization or Urgent/Emergent Care

WSP did well with appointments and scheduling for patients transferring from offsite hospitals. The OIG reviewed 26 events and found no deficiencies. The OIG reviewed six cases in which the patient was managed in the TTA at WSP and returned to housing. All follow-up appointments occurred without deficiency.

Specialized Medical Housing

WSP did well with provider follow-up visits in the CTC. The OIG reviewed 46 events and found five deficiencies, two of which were significant, and both in the same case:

- In case 16, there were two gaps in care where the patient was not seen by a provider for 7 and 11 days.

Specialty Access and Follow-up

WSP did well with appointments for specialty services and procedures. The OIG reviewed 50 events and found two deficiencies, both of which were significant:

- In case 9, the provider requested an infectious disease follow-up visit in two weeks, but the appointment occurred in five weeks.

- In case 16, the patient was not seen by the plastic surgery specialist for follow-up within the four-week time interval recommended. The patient paroled 12 weeks later without having received the follow-up visit.

Provider Follow-up After Specialty and Diagnostic Services

The OIG reviewed 50 events related to specialty services. All provider follow-ups occurred without deficiency.

Clinician Onsite Inspection

The leadership at WSP discussed the challenges of being a reception center and the high number of encounters required for the large patient population. They monitored appointments for backlogs, which occurred infrequently. Their success in managing this was helped by robust daily huddles in each health care area, which included all medical, nursing, custody, and support staff. During these huddles, the patients with appointment dates nearing out-of-compliance dates were given new,

earlier appointment times. Clinic staff all stated they had no appointment backlogs. Nurses and providers worked closely to manage sick call patients, often with joint visits. This led to more efficient care and fewer provider follow-up appointments. Leaders also stated that they used the OIG Cycle 4 inspection report for quality improvement in specialty services. The used a tracking system to manage appointments. This is further discussed in the *Specialty Services* indicator.

Case Review Conclusion

The WSP health care staff managed the challenges of a reception center with a large patient population and encounter rate well. The case review rating for this indicator was *adequate*.

Compliance Testing Results

WSP scored in the *adequate* range in the *Access to Care* indicator with a compliance score of 84.6 percent. The following four tests earned *proficient* scores:

- Inspectors sampled 35 Health Care Services Request forms (CDCR Form 7362) submitted by patients across all facility clinics. Nursing staff reviewed all service request forms on the same day they were received (MIT 1.003).

- Of the four patients sampled who were referred to and seen by a provider and for whom the provider subsequently ordered a follow-up appointment, all four received their follow-up appointments timely (MIT 1.006).

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

- Nursing staff completed a timely face-to-face triage encounter for all 35 sampled patients; however, for one patient, nursing staff did not document the required SOAPE assessment (97 percent) (MIT 1.004).

The institution scored in the *adequate* range on two tests, as follows:

- Among 25 patients sampled who transferred into WSP from other institutions and were referred to a provider based on nursing staff's initial health care screening, 20 (80 percent) were seen timely. One patient received his provider appointment 6 days late; the remaining four patients received their appointments 22, 38, 48, and 96 days late (MIT 1.002).

- Twenty of 25 sampled patients who were discharged from a community hospital (80 percent) received a timely PCP follow-up appointment upon their return to WSP. Five patients received their follow-up appointments one to four days late (MIT 1.007).

With *inadequate* scores, WSP showed room for improvement in the following three areas:

- Only 20 of 27 sampled patients who received a high-priority or routine specialty service (74 percent) also received a timely follow-up appointment with a provider. Among those seven patients who did not receive timely follow-up appointments, the following exceptions occurred (MIT 1.008):
    - One patient's high-priority specialty service follow-up appointment was one day late.
    - One patient's high-priority specialty follow-up did not occur.
    - Two patients' routine specialty follow-ups were 22 and 42 days late.
    - Two patients' routine specialty follow-ups did not occur.
    - For the final patient with a routine specialty service follow-up appointment, the provider did see the patient, but there was no discussion of the specialty service results, thus no true follow-up ever occurred.
- Inspectors sampled 25 patients who suffered from one or more chronic care conditions; only 17 patients timely received their provider-ordered follow-up appointments (68 percent). Eight other patients received their appointments late or not at all, including three patients whose follow up appointments occurred between one and two days late; but for five other patients, there was no medical record evidence found to indicate they were ever seen (MIT 1.001).
- Among eight service request forms sampled on which nursing staff referred the patient for a provider appointment, only five patients (62 percent) received a timely appointment. Two patients received their appointments 3 and 4 days late and one patient did not receive a provider visit at all (MIT 1.005).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(73.5%)

Overall Rating:
Adequate

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

For this indicator, the OIG's case review and compliance review process 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*. Although the compliance testing showed deficiencies in retrieval and scanning of radiology and pathology reports, the case review process found that these delays did not affect patient care, as the providers spent additional time to independently retrieve the results.

Case Review Results

The OIG clinicians reviewed 146 diagnostic events and found 17 deficiencies, 8 of which were significant. WSP performed well with regard to diagnostic services, and the indicator rating was *adequate*.

Appointment and Scheduling

Staff performed most laboratory tests, X-rays, and EKGs as ordered. However, there was one significant deficiency:

- In case 9, the provider ordered laboratory tests to recheck abnormal liver function be done on the same day; however, they were not done.

Health Information Management

Thirteen of the deficiencies in this indicator were due to an X-ray report not being retrieved or scanned into the electronic medical record. The OIG identified this problem in many Cycle 4 inspections, which are noted to continue into Cycle 5 inspections. Failure to retrieve radiology reports increases the risk of patient harm due to the chance of a lapse in care from a provider being unaware of the report. Even if the ordering provider was initially notified of the report and reviewed it, the report would still not be readily available to any subsequent medical staff. Any nurse or provider who cared for the patient in the coming months or years would face a tremendous barrier

in attempting to review radiology reports that had not been scanned into the electronic medical record.

The OIG clinicians identified deficiencies in the retrieval and scanning of radiology reports in cases 7, 13, 15, 16, and 17, twice in case 18, and three times in cases 8 and 19. WSP clinicians did a good job ensuring that the reports were reviewed despite the extra barrier to reviewing those results. However, in some cases, the report was not reviewed at all. The OIG found significant deficiencies in cases 16, 17, 18 (twice), and the following:

- In case 8, the chest X-ray radiology report showing possible lung cancer was not timely reviewed by the provider. Also in case 8, the CT scan eventually performed was also not timely reviewed. Fortunately, the results suggested chronic scarring, not cancer.

- In case 15, the patient had an abnormal chest X-ray shortly after transferring to WSP. This finding also could have represented a new lung cancer or infection. As this report was not in the electronic medical record, but only in the secondary depository, providers seeing the patient at multiple follow-up visits were unaware of a potentially serious finding. The patient had follow-up of this only by chance when he was admitted to a community hospital for pneumonia.

At the onsite inspection, WSP leadership explained that they had stopped scanning radiology reports from a secondary report repository into the primary electronic medical record (eUHR) based on a memo from CCHCS headquarters. Health care staff at WSP (and other CDCR institutions) now face a seemingly unnecessary barrier to the retrieval and review of those critically important reports, which creates an ongoing risk of lapses in care.

Case Review Conclusion

The OIG found that WSP performed well with regard to diagnostic services and, therefore, rated this indicator *adequate*.

Compliance Testing Results

The institution received a compliance score of 73.5 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Radiology services were timely performed for nine of ten patients sampled (90 percent); one patient received testing one day late (MIT 2.001). Radiology reports were only found in a non-electronic-medical-record databank (RIS-PACS). CCHCS policy requires providers to initial and date radiology reports to evidence having reviewed them; for none of the ten sampled reports did the provider provide this evidence by initialing and dating, for a score of

zero (MIT 2.002). However, providers did timely communicate the test results to nine of the ten patients (90 percent). In one case, there was no evidence that the provider communicated the test results to the patient (MIT 2.003).

Laboratory Services

- For nine of the ten sampled laboratory services (90 percent), the patients' ordered diagnostic services were timely performed; one patient's laboratory services were performed six days late (MIT 2.004). For nine of the ten sampled services (90 percent), the provider timely reviewed the laboratory report and timely communicated the result to the patient. In one case, although the provider initialed the report, no date was found (MIT 2.005). For nine of the ten sampled services (90 percent), the provider timely communicated the results of the laboratory study to the patient within specified time frames. In one case, although the notification of diagnostic test results was initialed, there was no signature or date (MIT 2.006).

Pathology Services

- WSP received four of the nine applicable final pathology reports timely (44 percent). Two diagnostic reports were received between 5 and 17 days late; in addition, three pathology reports were not found in the electronic medical record (MIT 2.007). Providers properly evidenced review of all applicable sampled final pathology reports by initialing and dating them (MIT 2.008). However, providers communicated pathology results timely to only four of the six applicable patients who received the service (67 percent). For two patients, the provider communicated the results between one and two days late (MIT 2.009).

3 — *EMERGENCY SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 31 urgent/emergent events and found 21 deficiencies, 6 of which were significant, in various aspects of emergency care.

Provider Performance

The OIG identified seven deficiencies in provider performance, one significant. The six minor deficiencies were all due to the provider on call not documenting the telephone call and management of the patient. In addition, for one of the minor deficiencies, the TTA nurse needed to contact an alternative physician as the provider on call was not reached in a timely fashion. The one significant deficiency for provider performance in Emergency Services was as follows:

- In case 1, the patient presented to the TTA with an elevated blood pressure of 160/100 and symptoms of headache, dizziness, and four days of left facial numbness. These symptoms, in a "worst case scenario," could be a possible stroke. A thorough history and neurological exam by a provider should have been performed, and if indicated, a CT scan of the head should have been conducted to rule out stroke. These symptoms were not adequately evaluated. Fortunately, the patient did not have a stroke.

Nursing Performance

In general, nurses at WSP provided good care during emergency medical response incidents. Although the majority of the nursing deficiencies were not significant and did not affect the patient's outcome, several case review examples demonstrated two areas for improvement.

One area of significant deficiencies was the implementation of timely nursing intervention and the accurate documentation of nursing assessments and interventions, as illustrated by the following cases:

- In case 1, an unexplained 45-minute delay occurred in transferring a patient found lying on the ground with fatigue and drowsiness to the TTA for evaluation. TTA nursing documentation showed an unexplained gap in care of 15 minutes after the patient arrived in the TTA until nurses first started nursing assessments. Nurses documented widely discrepant TTA arrival times with differences as much as 22 minutes, and incorrectly dated various nursing documents about this emergency response event.

- In case 6, the licensed vocational nurse (LVN) and psychiatric technician (PT) medical responders initiated low oxygen doses and connected the unresponsive patient with shallow breathing to the automated external defibrillator (AED). The LVNs did not consult an RN regarding increasing the oxygen dose per CCHCS nursing protocol for patients with loss of consciousness, and did not assess the patient's vital signs or activate the AED to check heart rhythm. Upon arrival in the TTA, nursing staff initiated CPR when they were unable to obtain the patient's vital signs and the AED advised chest compressions. Documentation by the LVN first responder and the TTA nurse had discrepant entries about the time and the patient's status on arrival in the TTA.

The second key area of significant deficiencies was the patient care environment specifically related to availability of pertinent onsite communications support and necessary equipment for medical staff at the time of emergency medical responses.

- In case 1, the custody staff in the watch commander's office did not answer the phone when TTA staff called for a Code 3 (emergent) ambulance for transfer to a community hospital for a higher-level evaluation. The request to County Emergency Medical Services for a Code 3 ambulance transport to by the watch commander's office was delayed 13 to 15 minutes.

- In case 3, the medical responder arrived on scene, and the pulse oximeter (machine to check circulating oxygen level) was not available in the emergency response bag. The nurse could not insert an intravenous fluid line and administer medications because necessary equipment was not available in the yard clinic.

- In case 4, the RN emergency responder was unable to assess the unresponsive patient's circulating oxygen level because the pulse oximeter was malfunctioning.

Health Information Management

Documentation in the TTA was good. The OIG reviewed 32 TTA encounters at WSP and identified only three minor deficiencies. These included documents misdated by one day and one record with a time stamp partially obscuring other parts of the record.

Emergency Medical Response Review Committee

The Emergency Medical Response Review Committee (EMRRC) reviewed Code 2 and Code 3 unscheduled medical transports to community hospitals for a higher level of care. However, the EMRRC did not address the malfunctioning and unavailable equipment (pulse oximeter) in its reviews of emergency responses in cases 3 and 4.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians found the patient care TTA environment was neat and well organized for providing emergent medical care. The TTA had an adequate number of experienced nurses, access to online patient records, and supplies and equipment for the usual medical response activities. Nursing administrators at WSP acknowledged issues with time discrepancies in emergency medical response documentation, and described various strategies underway for improvement. Strategies included identification of a designated "recorder" during the morning huddle for emergency medical responses in each yard during clinic hours, and documenting emergency response entries in timeline format rather than a generalized summary of assessments, interventions, and results. The plan of action also included providing training sessions for LVN and PT emergency medical responders regarding oxygen doses, and working with administrators to establish an emergency medical vehicle stocked with necessary equipment and supplies for providing emergency care outside of the TTA.

Case Review Conclusion

Overall, the case reviews showed that patients requiring urgent or emergent services received adequate and timely care in the majority of cases reviewed. Nursing administrators were aware of the issues identified in the case review, and had initiated interventions to make improvements. The OIG rated this indicator *adequate*.

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(70.0%)

Overall Rating:
Inadequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. After considering both case review and compliance testing results, the OIG inspection team determined the final overall rating of *inadequate* was appropriate. This decision was primarily due to an excessive number of health care documents that WSP staff either mislabeled or misfiled in the electronic medical record. This could result in important health care records not being identified, which could contribute to patient harm.

During the OIG's testing period, WSP had not converted to the new Electronic Health Record System (EHRS) (expected transition October 2017); therefore, all testing for WSP in Cycle 5 occurred in the electronic Unit Health Record (eUHR) system.

Case Review Results

The OIG clinicians reviewed 764 events and found 29 deficiencies related to health information management, 10 of which were significant. Six of the deficiencies (once in cases 16 and 17, and twice in cases 8 and 18) were when X-ray reports were not scanned into the electronic medical record, which was explained by the institution's understanding of a CCHCS directive to not scan X-ray reports. This is discussed in detail in the *Diagnostics Services* indicator. The OIG clinicians rated this indicator *adequate*.

Interdepartmental Transmission

The OIG did not identify any problems in communication between the departments within the institution.

Hospital Records

The OIG reviewed 22 outside emergency department and community hospital events. There were four deficiencies, one of which was significant (case 1). The institution generally performed well in

retrieving emergency department physician reports and hospital discharge summaries as well as forwarding the reports to the provider for review, with only one not signed properly. The one significant deficiency occurred in the case of a patient who died in the hospital:

- In case 1, the hospital discharge summary was scanned into the electronic medical record ten days after it was received from the hospital.

Specialty Services, Diagnostic Reports, and Urgent/Emergent Records

WSP did well with retrieval and scanning of most records for specialty services. These events are discussed in the *Specialty Services* indicator (case 16 had two significant deficiencies). The OIG reviewed 32 TTA encounters at WSP, and identified three minor deficiencies. These are discussed further in the *Emergency Services* indicator.

Scanning Performance

The WSP scanning deficiencies were mostly minor. They consisted of scanning with incorrect labels (cases 1, 5, 14, 16, 17, 23, and 26), scans missing altogether (cases, 13, 14, 24, and 52, and two in case 9), or failing to have a provider sign the report (cases 9, 12, 13, and 18). One significant deficiency occurred when one page of a county correctional document was not scanned into the eUHR (case 52).

Clinician Onsite Inspection

While onsite, the OIG discussed some of the health information management deficiencies identified during the case review. The medical records supervisor was able to review the issues found, and had already put into place appropriate training and corrective plans. The supervisor indicated corrective actions in place to improve accuracy and timeliness of scanning. This efficient corrective action likely explained the improvement found in health information management at WSP from the OIG's Cycle 4 medical inspection, with a reduction in both minor and significant deficiencies in this indicator.

Case Review Conclusion

The OIG clinicians rated WSP *adequate* in this indicator.

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.0 percent in the *Health Information Management* indicator, showing room for improvement in the following areas:

- The institution scored zero in its labeling and filing of documents scanned into patients' electronic unit health records. Most errors included mislabeled and misfiled documents. However, there was also a missing Non-CDCR Hospital Admission Report and one instance of a medication reconciliation order scanned into the incorrect patient's file. For this test,

once the OIG identifies 24 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. For the WSP medical inspection, inspectors identified a total of 30 documents with scanning errors, 6 more than the maximum allowable errors (MIT 4.006).

- For 14 of 20 specialty service consultant reports sampled (70 percent), WSP staff scanned the reports into the patient's health record file within five calendar days. However, three documents were scanned between two and five days late; also for three other documents, no evidence was found that they were actually scanned (MIT 4.003).

The following two tests earned *adequate* scores:

- WSP's medical records staff timely scanned miscellaneous non-dictated documents such as provider progress notes, nursing initial health screening forms, and patient requests for health care services. Specifically, 16 of the 20 documents sampled (80 percent) were timely scanned into the patient's electronic medical record within three calendar days of the patient's encounter. For four patients, a provider's progress note was scanned between one and 25 days late (MIT 4.001).

- The OIG reviewed community hospital discharge reports and treatment records for 25 sampled patients sent to an outside hospital. For 20 of the 25 patients (80 percent), the discharge summary reports were complete and timely reviewed by WSP providers. For one patient, WSP providers reviewed the hospital discharge summary reports one day late. For four patients, the discharge report was missing key information and there was no evidence that WSP followed up with the hospital to obtain it (MIT 4.007).

The institution scored in the *proficient* range on two tests in this indicator:

- WSP medical records staff timely scanned medication administration records (MARs) into the patients' electronic medical records in 18 of 19 samples tested (95 percent). One MAR was scanned one day late (MIT 4.005).

- The OIG also tested 20 of the patients' discharge records to determine if staff timely scanned the records into the patient's electronic medical record. Nineteen of the 20 samples (95 percent) were compliant. One record was scanned one day late (MIT 4.004).

5 — *HEALTH CARE ENVIRONMENT*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(65.0%)

Overall Rating:
Inadequate

This indicator is evaluated entirely by compliance inspectors, so there is no case review component.

Compliance Testing Results

The institution received an *inadequate* compliance score of 65.0 percent in the *Health Care Environment* indicator, showing need for improvement the following areas:

- The non-clinic bulk medical supply storage areas did not meet the supply management process or support the needs of the medical care program, earning a score of zero on this test. Specifically, WSP health care management expressed concerns about having poor cooperation between warehouse staff and medical supply staff, and inspectors found medical supplies that were stored beyond manufacturers' guidelines (MIT 5.106).

- Only two of nine clinic locations (18 percent) met compliance requirements for essential core medical equipment and supplies. The remaining seven clinics displayed one or more of the following deficiencies (MIT 5.108):

    - Four clinic exam rooms did not have a biohazard receptacle or bags.

    - Four clinic exam rooms did not have operational oto-ophthalmoscopes.

    - Two clinic exam rooms did not have hemoccult cards or developer.

    - Two clinic exam rooms did not have an established distance line for the Snellen eye chart.

    - One clinic had a weight scale with a missing calibration sticker.

    - One clinic exam room had a broken overhead light and was missing disposable paper on the exam table and lubricating jelly.

- Only 6 of 11 clinics demonstrated proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. WSP received a score of only 55 percent on this test

because five clinics had one or more exam rooms that lacked a sharps container (MIT 5.105).

- Clinicians followed good hand hygiene practices in only six of the ten clinics the OIG observed (60 percent). At four clinic locations, clinicians failed to wash their hands before or after patient contact or before applying gloves (MIT 5.104).

- Only 7 of 11 clinic exam rooms observed (64 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations. Four clinic exam rooms had confidential records that were accessible to inmate porters because they had not been destroyed properly, and two clinic exam rooms had exam tables with torn vinyl (*Figure 1*). One clinic exam room did not offer the patient visual privacy, and another clinic exam room did not have properly labeled cabinets (MIT 5.110).

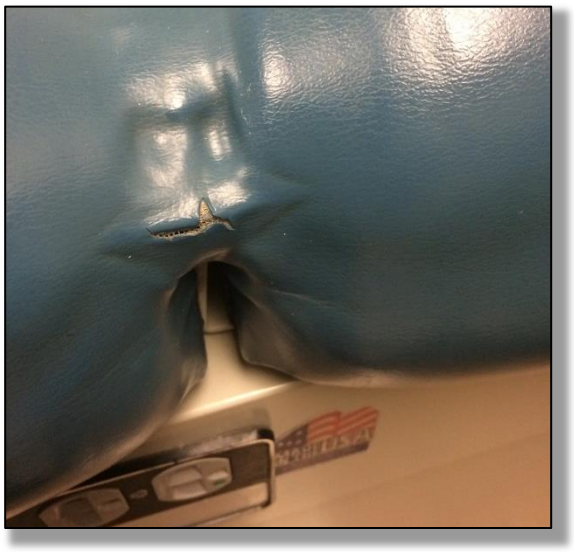

Figure 1: Torn vinyl on exam table.

- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. Emergency response bags were compliant in only 7 of the 11 clinical locations where they were stored (64 percent). At two clinic locations, the oxygen tank was not at the required pressure. One clinic location had a bag that was missing a medium size airway, and one other clinic locations was missing a large size blood pressure cuff (MIT 5.111).

The following tests earned WSP *adequate* scores:

- Of the 11 clinic locations inspected, 9 (82 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the exam areas. However, two clinics' patient restrooms were without antiseptic soap, and one of those also lacked disposable towels (MIT 5.103).

- Inspectors found that 9 of the 11 applicable clinics (82 percent) followed adequate medical supply storage and management protocols. At one clinic, a provider did not have access to scissors to remove a patient's bandages, and at another clinic, medical supplies were stored in the same location as cleaning supplies (MIT 5.107).

The institution scored in the *proficient* range in three tests, as follows:

- All 11 clinics were appropriately disinfected, cleaned, and sanitary. More specifically, in all clinics, inspectors observed areas that were clean and not visibly dusty or dirty. In addition, cleaning logs were present and completed, indicating cleaning crews regularly cleaned the clinic (MIT 5.101).

- Clinical health care staff at all 11 applicable clinics ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected (MIT 5.102).

- Clinic common areas at 10 of the 11 clinics (91 percent) had environments conducive to providing medical services. One clinic common area did not provide patient auditory privacy at the triage and vital sign check stations because the area was also used as a waiting area for clinical appointments (MIT 5.109).

Non-Scored Results

- The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. The OIG did not score this question. When OIG inspectors interviewed health care managers, they did not identify any significant concerns. At the time of the OIG's medical inspection, WSP had several significant infrastructure projects underway, which included construction and renovation improvements on Yards A, B, C, and D, and the R&R, as well as the construction of new medication distribution rooms in the institution. These projects began in January 2016, and all projects were scheduled to be completed by September 2018 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Adequate
Compliance Score:
Proficient
(86.3%)

Overall Rating:
Proficient

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include patients received from other CDCR facilities and patients 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 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.

In this indicator, the OIG's case review and compliance testing 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 the factors that led to both scores. The clinicians found a relatively low number of deficiencies in this indicator, so the compliance result of *proficient* was the appropriate overall rating for this indicator.

Case Review Results

The OIG clinicians reviewed 35 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. These included 26 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.* Of the 35 encounters reviewed, seven deficiencies were identified, of which two were significant (cases 1 and 9, discussed below).

Transfers In and Out and Hospitalizations

One minor nursing documentation omission deficiency occurred in all the transfer cases reviewed. 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 two significant deficiencies in this indicator were in this area:

- In case 1, the patient had been admitted to the community hospital for altered consciousness and respiratory failure. He developed seizures in the emergency department and was admitted to the intensive care unit, where his condition worsened and he eventually died. There was a significant delay in the retrieval and review of the hospital discharge summary. The summary was dictated at the hospital 20 days after the patient's death, and the institution signed and scanned the report 12 days after that.

- In case 9, the patient returned from a hospitalization with elevated liver function tests and on high doses of a seizure medication that can be toxic to the liver. The hospital physician had discontinued the medication and recommended an alternative seizure medication. The WSP provider was aware of the hospital discharge medication change recommendations, but failed to make the change to a different medication.

Clinician Onsite Inspection

Patients returning from hospital discharge were assessed by the TTA nurse. The case reviews supported evidence that nursing staff completed patient assessment, reviewed hospital discharge recommendations with the provider, and made appropriate follow-up referrals.

Case Review Conclusion

The *Inter- and Intra-System Transfers* indicator at WSP was *adequate*. The staff and processes involved with inmate transfers were well organized and coordinated, and they contributed to continuity of health care services for transferring inmates.

Compliance Testing Results

The institution obtained a *proficient* score of 86.3 percent in the *Inter- and Intra-System Transfers* indicator, with three tests scoring in the *proficient* range, as follows:

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

- Nursing staff timely completed the assessment and disposition sections of the screening form on the same day staff completed the health screening for 23 of 24 applicable patients (96 percent). For one patient, nursing staff completed the assessment and disposition one day after the health screening (MIT 6.002).

- For 22 out of the 25 sampled patients who transferred into WSP from other CDCR facilities (88 percent), nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived. For one patient, there was no evidence in the electronic medical record that staff completed the form. For another patient, staff failed to complete the

form; for one other patient, staff dated the form one day prior to the patient's actual arrival (MIT 6.001).

The institution earned an *adequate* score in one test in this indicator:

- Inspectors sampled 20 patients who transferred out of WSP to other CDCR institutions to determine whether WSP identified scheduled specialty service appointments on the patients' health care transfer forms. Nursing staff correctly listed the pending specialty service appointments for 15 of 20 patients (75 percent). Staff failed to list pending specialty services for five patients (MIT 6.004).

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

- Of 25 sampled patients who transferred into WSP, 11 had an existing medication order upon arrival; only 8 of the 11 applicable patients (73 percent) received their medications without interruption. Three patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(62.6%)

Overall Rating:
Inadequate

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

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

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied on for the overall rating of this indicator. The OIG clinicians evaluated 31 events related to medications and found four minor deficiencies.

Medication Continuity

Patients received their medications as prescribed and timely as scheduled with one exception:

- In case 3, the patient arrived at WSP from a county correctional facility, and did not receive his prescribed antidepressant and antipsychotic medications on the day of arrival. The patient received the prescribed medications the following day.

Medication Administration (Nursing)

Nursing staff performed adequately regarding accurate and timely administration of prescribed keep-on-person (KOP) and nurse-administered medications. Although there were no significant

deficiencies identified in the cases reviewed, there were some deficiencies that warranted quality improvement interventions.

- In case 8, the provider ordered a cholesterol medication for 10 days, but it was not given to the patient on two of the next ten consecutive days. There was no documentation on the patient's MAR to indicate whether the patient refused the medication or was offsite on those two days.

- In case 53, the patient with elevated blood glucose refused his insulin dose and signed a refusal of treatment form. The nurse did not notify the provider about the patient's elevated blood glucose level or his refusal of insulin.

Pharmacy Errors

- In case 15, the pharmacy failed to catch the provider's medication order error for concurrent prescriptions. The provider had ordered both albuterol and levalbuterol inhalers for a patient with chronic obstructive pulmonary disease. These medications are essentially the same, and only one should be prescribed at a time.

Clinician Onsite Inspection

The OIG clinicians found the LVNs and PTs responsible for medications to be knowledgeable about their patients, medication preparation and administration safety, and operational processes on their assigned yards, and they were located in close proximity to the clinic primary care nurses and providers. These LVNs and PTs described an appropriate process at WSP for verifying new medication orders and reconciling continuing medication orders. These clinical staff members were an integral part of the larger primary care team on each yard by also serving as first medical responders for medical emergencies during hours of clinic operations.

Case Review Conclusion

Since the identified medication errors did not pose dangers to the patients, the OIG clinicians rated pharmacy and medication administration at WSP *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 62.6 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *adequate* score of 79.7 percent, scoring in the *proficient* range in two tests, as follows:

- Inspectors reviewed files of nine applicable patients who recently arrived at WSP from a county jail for whom a WSP provider had ordered medications upon their arrival. Inspectors found that all nine applicable patients received their medications timely. As a result, WSP received a score of 100 percent for this test (MIT 7.004).

- Inspectors found that 24 of 25 patients sampled (96 percent) received their newly ordered medication in a timely manner. For one patient, staff failed to date the MAR, so there was no evidence that the patient received medication within the required time frame (MIT 7.002).

The institution scored in the *adequate* range on two tests in this sub-indicator:

- Among 19 sampled patients, 16 (84 percent) timely received their chronic care medications. Three patients either did not receive all ordered medications or did not receive required counseling for missed doses (MIT 7.001).

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

The final two tests in this sub-indicator showed areas for improvement at WSP:

- Nursing staff administered medications without interruption to seven of ten patients who were en route from one institution to another and had a temporary layover at WSP (70 percent). For two patients, there was no evidence found that medications, including those for HIV and high blood pressure, were administered as ordered. For one patient, there was no evidence that one of his medications was given (MIT 7.006).

- WSP timely provided hospital discharge medications to 11 of 25 patients sampled (44 percent). Providers did not prescribe discharge medications within the required time frame for six patients. For two patients, medications were not dispensed as ordered; six other patients did not timely receive ordered medications (MIT 7.003).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *inadequate* score of 51.6 percent. Four tests scored in the *inadequate* range, as follows:

- WSP properly stored non-narcotic medications not requiring refrigeration in only two of the ten applicable clinic and medication line storage locations (20 percent). In eight locations, one or more of the following deficiencies were observed: four locations had internal and external medications stored together; three locations did not have an identifiable system for return-to-pharmacy medications; one medication location had a single-dose medication used as a multi-dose diluent; another medication line location had pre-filled syringes without a label to identify the medication; and one other location had a medication not marked with the date it was opened (MIT 7.102).

- Non-narcotic refrigerated medications were properly stored at only two of ten clinics and medication line storage locations (20 percent). At eight locations, there was no clearly identified process in place to separate return-to-pharmacy medications, and one of the medication lines also had a medication not marked with the date it was opened (MIT 7.103).

- The institution employed adequate security controls over narcotic medications in three of the eight applicable clinic and medication line locations where narcotics were stored (38 percent). At five medication line locations, the narcotics log books did not have nursing co-signatures for shift counts on multiple dates (MIT 7.101).

- Inspectors observed the medication preparation and administration processes at seven applicable medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at four locations (57 percent). At three locations, not all nursing staff washed or sanitized their hands when required, such as prior to putting on gloves and administering medications and before each subsequent re-gloving (MIT 7.104).

The institution received an *adequate* score on the following test in this sub-indicator:

- Nursing staff followed appropriate administrative controls and protocols when distributing medications to patients at six of eight applicable medication preparation and administrative locations (75 percent). At two medication line locations, there was insufficient overhang or shade protection during extreme heat or inclement weather (*Figure 2*) (MIT 7.106).

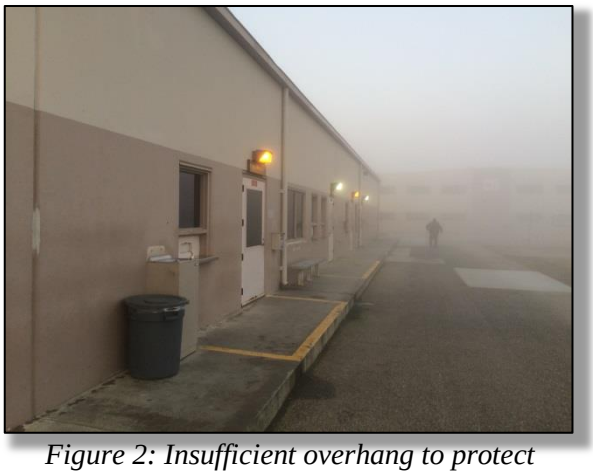

Figure 2: Insufficient overhang to protect patients waiting at pill lines from inclement weather or extreme heat

One test earned WSP a *proficient* score of 100 percent:

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

Pharmacy Protocols

In this sub-indicator, the institution received an average score of 55.2 percent, comprised of scores received at the institution's main pharmacy. The following two tests earned scores of zero:

- In its main pharmacy, WSP did not properly store non-refrigerated medication. Inspectors found food items stored in the same location as medications (MIT 7.108).

- Inspectors found that WSP pharmacy staff did not properly account for narcotic medications. Pharmacy staff did not complete a narcotics count for an entire month during the inspection period (MIT 7.110).

One test in this indicator scored in the *adequate* range:

- The institution's pharmacist in charge followed required protocols for 19 of the 25 medication error reports and monthly statistical reports reviewed (76 percent). There was no evidence that five sampled medication error reports were shared with the local Pharmacy and Therapeutic Committee and applicable quality improvement committees. One sampled report was completed one day late (MIT 7.111).

Two tests earned *proficient* scores of 100 percent:

- The institution's main pharmacy properly stored all refrigerated and frozen medications (MIT 7.109).

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols (MIT 7.107).

Non-Scored Tests

- In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; however, at WSP, the OIG found no applicable medication errors with which to conduct this test (MIT 7.998).

- Inspectors interviewed patients housed in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. Nine of ten applicable patients interviewed indicated they had access to their rescue medications. One patient indicated that he had disposed of his inhaler. Upon notification, WSP took timely action to replace the patient's inhaler (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

Because WSP housed only male patients, this indicator did not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(71.4%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 71.4 percent. Areas showing room for improvement were as follows:

- OIG inspectors sampled 30 patients to determine whether they received a TB screening within the last year. Among the 30 sampled patients, 15 were classified as a Code 22 (requiring a TB skin test in addition to a signs and symptoms check), and 15 sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check). Of all 30 sampled patients, nursing staff timely and appropriately conducted those screenings for only 14 (47 percent). More specifically, nurses properly screened 12 of the Code 22 patients and 2 of the Code 34 patients. Inspectors identified the following deficiencies (MIT 9.003):
    - For one Code 22 patient, nursing staff's documentation of the signs and symptoms review was incomplete, and for two patients, the history section was incomplete.
    - For 13 Code 34 patients, nursing staff did not complete the required history section review of the Tuberculin Testing/Evaluation Report (CDCR Form 7331).
- The OIG tested whether WSP offered required influenza, pneumococcal, and hepatitis vaccinations to patients who suffered from a chronic care condition; only 10 of the 18 patients sampled (56 percent) were offered them. For eight patients, inspectors did not find evidence that the patients were offered the recommended pneumococcal or hepatitis vaccinations (MIT 9.008).
- The institution scored poorly for monitoring of patients on TB medications. For 10 of 24 patients sampled, the institution either failed to complete monitoring at all required intervals,

failed to document weight monitoring, or failed to scan the monitoring form into the patient's medical record in a timely manner (58 percent) (MIT 9.002).

Two tests earned *adequate* scores:

- WSP scored 80 percent for administering timely TB medications to patients with TB. Twenty of 25 patients received their medication timely, while three patients missed one to five required medication doses and did not receive the required provider counseling for the missed dosage. For two patients, no evidence was found in the electronic medical record that they received medications for an entire month (MIT 9.001).

- The OIG sampled 20 patients at high risk for contracting 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. WSP was compliant for 15 of the 20 patients sampled, scoring 75 percent. The five remaining patients were transferred out of WSP 2, 7, 9, 10, and 96 days late (MIT 9.009).

The institution scored in the *proficient* range in two tests in this sub-indicator, as follows:

- WSP offered annual influenza vaccinations to 24 of 25 sampled patients subject to the annual screening requirement (96 percent). For one patient, there was no medical record evidence found that health care staff offered an influenza vaccination within the most recent flu season (MIT 9.004).

- WSP offered colorectal cancer screenings to 22 of 25 sampled patients subject to the annual screening requirement (88 percent). For one patient, there was no medical record evidence either that health care staff offered a colorectal cancer screening within the previous 12 months or that the patient had a normal colonoscopy within the last ten years. Also, for two patients whose colonoscopies were abnormal, there was no medical record evidence that health care staff offered a colorectal cancer screening within the previous 12 months (MIT 9.005).

10 — *QUALITY OF NURSING PERFORMANCE*

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 256 nursing encounters, of which 125 were outpatient nursing encounters. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN care manager follow-up visits. In all, there were 40 deficiencies related to nursing care services, of which 11 were significant. The *Quality of Nursing Performance* indicator at WSP was rated *adequate*.

Nursing Assessment

A major part of providing adequate nursing care is the quality of nursing assessments, including both the subjective (patient interview) and the objective (evaluation and observation) portions. The majority of nurses at WSP consistently included both subjective and objective nursing assessments of their patients. During the case review process, one area of nursing services that particularly stood out as a positive was the provision of comprehensive patient-specific nursing assessments by staff in the reception center.

Nursing Intervention

A major determining factor in appropriate nursing interventions is the performance of an accurate assessment. Since nurses at WSP usually performed appropriate assessments, nursing interventions were also usually timely and appropriate. However, there were several minor deficiencies that demonstrated areas to target for system evaluation, staff education, and other quality improvement strategies, as follows:

- In case 16, the newly-discharged patient from the CTC had refused his dressing changes for several days, and the LVNs did not notify the RN care manager or the provider. Additionally, one LVN decided to discontinue the ordered ointment application to the wound without contacting the provider or receiving an order for discontinuation.

- In case 20, the provider ordered finger-stick blood glucose to be checked in the morning and before meals for three weeks for the diabetic patient. These blood glucose checks were not done.

Nursing Documentation

Nursing documentation in all areas of nursing services was generally good at WSP. However, there was a noticeable pattern of documentation deficiencies. There were frequent inconsistencies in the documentation of the timeline, or sequence of events, from different nurses involved in the emergency medical response (also discussed in the *Emergency Services* indicator). Although not significant, the following deficiencies displayed areas to target for further nursing evaluation and quality improvement:

- In case 8, the patient in the CTC developed a fever and was sent offsite to a community hospital. The nurse did not document an assessment of the patient's condition or nursing interventions that led up to sending the patient out for a higher level of care. Additionally, the patient's vital signs were documented as taken at a time after he had been transported out of the institution to the hospital.

- In case 16, a third-watch CTC nurse consistently documented a dressing change regimen that was different from the most recent wound care orders.

Sick Call

The sick call process at WSP was timely and met the majority of patients' needs regarding access to health care services. However, aspects of the sick call process clearly indicated a need for targeted quality improvement strategies. Although sick call nurses generally performed appropriate nursing assessment and intervention, there were cases in which patients were not assessed timely or appropriately based on the symptoms they described on the sick call request (CDCR Form 7362). The following examples of minor deficiencies illustrate this pattern:

- In case 10, the patient submitted a sick call request for chest pain and shortness of breath. The sick call nurse did not assess the patient until three hours after reviewing the request form, at which time the patient was transferred to the TTA and eventually out to a community hospital for a higher level of care.

- In case 17, the patient had been sent out to the emergency room for kidney stones. After returning to WSP, he repeatedly submitted sick call requests for painful urination, blood in his urine, vomiting, diarrhea, continuing to pass kidney stones, and renewal of his prescribed

pain medication. On numerous occasions, the sick call nurse did not provide a face-to-face assessment of the patient, and did not refer him to a provider even after receiving the third request for the same complaint. On one occasion when the sick call nurse did see the patient at a face-to-face visit for vomiting and diarrhea (for four days), blood in the urine, and kidney stone pain, the nurse did not assess the patient's vital signs or order a urinalysis.

- In case 35, the patient, who was being followed in the oncology (cancer) clinic, submitted a sick call request for renewal of his pain medication for continuing chronic pain. The patient's last administered dose of pain medication had been two days prior to the sick call visit according to his medication administration record. The sick call nurse did not assess the patient's pain level, document the location of his pain, or notify the provider about the pain medication. The patient did not receive his pain medication until two weeks later when the provider renewed the pain medication at a follow-up visit.

Care Management

The role of the RN primary care manager includes assessing patients, initiating appropriate interventions to support goals in the patient's treatment plan, and monitoring patients with chronic health needs and those at increased risk for developing serious health complications. Although not significant, the following case reviews demonstrated the need for evaluation of the communication processes in place at WSP for notifying the RN primary care managers about the needs of patients upon discharge from the CTC, thereby supporting their ability to appropriately assess, coordinate, and advocate for needed health care services.

- In case 16, the patient with a recurrent slow-healing leg wound infection had been treated with antibiotics in the CTC and was discharged with orders for daily wound care and physical therapy. The RN care manager assessed the patient four days after his discharge from the CTC and addressed his long-term chronic health conditions. However, the RN care manager did not address the patient's daily refusals of wound care and physical therapy during the three days since his discharge from the CTC.

- In case 17, the RN care manager assessed the patient five days after his discharge from the CTC, where he had been treated for pancreatitis (pancreas inflammation) and pneumonia. The RN care manager did not address the patient's status after CTC discharge or his use of a rescue inhaler (for sudden wheezing) and pain management since the CTC discharge.

Urgent/Emergent Care

Although issues with malfunctioning medical equipment were identified in the case reviews, the medical responders and TTA nurses provided appropriate care to patients during emergency medical responses. The clinic LVNs and PTs serve as first medical responders in the yards at WSP. The OIG clinicians identified issues that fell into two patterns of deficiencies in the cases reviewed. One pattern was that the LVNs and PTs always administered the lowest dose (2 liters per minute) of

oxygen when higher doses (up to 6 liters per minute) would have been more appropriate. The second pattern of deficiencies was the timeline documentation inconsistencies of emergency response events. This is further discussed in the *Emergency Services* indicator.

After Hospital Returns

Patients returning to WSP after hospital discharge were assessed by a TTA nurse and received appropriate nursing assessments and follow-up referrals. The TTA nurses reconciled discharge recommendations from the hospital with the provider, and most patients received medications and treatments as recommended. This is further discussed in the *Inter- and Intra-System Transfers* indicator.

Specialized Medical Housing

CTC nurses provided adequate nursing care services. This is further discussed in the *Specialized Medical Housing* indicator.

Transfers and Reception Center

Nurses in the reception center provided adequate nursing care services and documentation. This is further discussed in the *Inter- and Intra-System Transfers* and *Reception Center* indicators.

Offsite Medical Return and Specialty Care

The telemedicine nurse did not review the most current patient information prior to scheduled telemedicine appointments. However, during the onsite visit, nursing administrators indicated the telemedicine nurse and backup nurse had been provided education about conducting a comprehensive review for current patient information prior to telemedicine appointments to ensure the most current information is made available for telemedicine appointments. This is further discussed in the *Specialty Services* indicator.

Medication Administration

System processes in place at WSP supported nursing and pharmacy staff in providing timely medication administration to patients. This is further discussed in the *Pharmacy and Medication Management* indicator.

Clinician Onsite Inspection

The OIG nurse clinicians attended the weekly WSP Supervising Nurses meeting during the onsite visit. The CNE facilitated the lively, well-attended meeting in which nursing supervisors discussed topics such as plans for implementation of the EHRS, status updates on various nursing projects, potential educational strategies, and suggestions for staff morale-boosting activities to implement for the upcoming National Nurses Week event at WSP.

Case Review Conclusion

The OIG nurse clinician team facilitated a meeting with the CNE and nurse supervisory team to discuss the case review and onsite visit findings. The WSP nurse managers had done their research on the cases presented and were well prepared to address the issues and interventions underway for improvement. The OIG commended the WSP nurses for their successful implementation of the excellent care team huddle process established in the clinics and CTC, the cohesiveness and involvement of the nurse management and supervisory team, and the good morale observed among all levels of nursing staff in each nursing service area. The OIG rated the *Quality of Nursing Performance* indicator at WSP *adequate*.

11 — *QUALITY OF PROVIDER PERFORMANCE*

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 149 medical provider encounters and identified 62 deficiencies related to provider performance, 26 were significant. Ten of the significant deficiencies occurred in the CTC and contributed to the *inadequate* rating of the *Specialized Medical Housing* indicator. As such, they are weighted less in this *Quality of Provider Performance* indicator. The OIG reviewed 20 detailed case reviews, and found one *proficient*, 13 *adequate*, and 6 *inadequate*. The OIG clinicians rated this indicator *adequate*, but identified areas still needing improvement.

Assessment and Decision-Making

Some provider decisions were excellent and exceeded expectations:

- In case 10, a patient returned from an outside hospital after a heart attack. The patient refused important testing in the hospital to determine if another heart attack was likely to occur in the future. The patient left against medical advice and returned to WSP. The WSP primary care provider spent considerable time and discussion to convince the patient to have the additional testing. The patient ultimately agreed to have the testing, which was emergently needed in a few days when he had another massive heart attack. This required complex, lifesaving surgery.

Some provider decisions were problematic. The following cases are also discussed in the *Specialized Medical Housing* indicator:

- In case 8, the provider demonstrated poor clinical judgment when this patient was scheduled for non-urgent surgery. The patient had had a blood clot in his legs two weeks earlier. The surgery should have been delayed until a time when blood-thinning medications could more safely have been temporarily stopped. Fortunately, no harm came to the patient when the blood-thinning medication was stopped.

- Again in case 8, the regular provider misinterpreted laboratory studies. A very elevated ferritin (iron) level was incorrectly interpreted as indicating that the patient was iron deficient. The provider inappropriately prescribed iron supplements.

- In case 14, there was no adjustment to increase warfarin (blood thinner) after a third laboratory test showed a low therapeutic level.

- In case 15, the TTA provider failed to administer an antidote for a possible narcotics overdose to an unconscious patient with signs upon physical examination that strongly suggested he had overdosed. Fortunately, the patient had not overdosed, but instead had had a severe infection.

- In case 16, the provider failed to recognize that only ten days of antibiotics was insufficient for a wound caused by a bone infection. The provider also failed to order diagnostic tests to ensure treatment was complete. Finally, the provider failed to appropriately examine the wound. The wounds never healed over the months of medical care reviewed.

Review of Records

Some errors were likely a result of providers being unfamiliar with a patient in the CTC because of spending insufficient time to review the medical records. These deficiencies are described in detail in the *Specialized Medical Housing* indicator. Other examples in outpatient care where significant deficiencies resulted from incomplete record review are as follows:

- In case 1, the provider evaluated the patient two days after a recent TTA visit. The provider failed to review the TTA visit and did not address the new symptom of facial numbness. A complete examination, and likely a CT scan of the head, should have been performed to eliminate stroke as the cause.

- In case 9, there were three significant deficiencies. The provider reviewed the hospital discharge summary and did not address the hospitalist's recommendation for discontinuing valproic acid (seizure medication). By reordering the valproic acid, a medication known for causing liver injury in some patients, the provider placed the patient with elevated liver enzymes at risk for further liver damage. On another encounter, the provider reviewed laboratory tests showing an elevated valproic acid level. Again, the provider failed to address the elevated valproic acid level in a patient with elevated liver enzymes. Finally, on another encounter, the provider evaluated the patient after another hospitalization, but did not address the hospitalist's discharge diagnosis of hyponatremia (low salt level) and elevated liver enzymes, likely due to medication.

- In case 12, the provider failed to review the laboratory tests, even though test result review was one of the reasons for the medical appointment. This resulted in the patient's new diagnosis of hepatitis C being overlooked and unaddressed.

- In case 17, the provider failed to review the CT scan showing the presence of a kidney stone.

Chronic Care

The providers sometimes provided poor care for patients with chronic medical conditions, as illustrated in the following examples:

- In case 17, the provider refilled a narcotic pain medication without an appropriate evaluation or follow-up visit.

- In case 17, on another encounter, the provider failed to appropriately adjust insulin for a patient with high bedtime glucose levels. The provider inappropriately increased the long-acting insulin, which placed the patient at risk for low morning glucose levels. The provider also ordered an inappropriately long follow-up interval of 90 days before the next appointment. In addition, the patient's chronic hepatitis C infection was not addressed.

- Also in case 17, on another encounter, the provider failed to manage recent findings of a kidney stone on a CT scan and a TTA visit with blood in the urine. The provider failed to consider many other causes of the patient's abdominal discomfort other than kidney stones.

- In case 19, the provider did not address the asthma patient's shortness of breath and poor control of asthma.

- In case 20, on three encounters, the providers failed to appropriately treat a patient with high blood glucose average (HemA1c rising to 9.9).

- In case 21, the provider did not adequately manage a very high glucose average (HemA1c of 9.9) by only increasing metformin, one type of diabetes medication. Without adding a second diabetes medication, this one change would not be expected to have the patient's glucose level at target.

Urgent/Emergent Care

The providers performed well in emergency services, with one significant deficiency. Most minor deficiencies were the on-call provider's failures to record a telephone call progress note. There was one event in which the provider failed to fully evaluate a patient in the TTA with elevated blood pressure and new neurological symptoms that suggested an acute stroke (case 1). This is also discussed in the *Emergency Services* indicator.

Specialty Services

Provider performance related to specialty services was good. The case review process did not find any deficiencies in provider performance. This is also discussed in the *Specialty Services* indicator.

Specialized Medical Housing

There were ten significant deficiencies identified for WSP in this area. Most occurred during the care given to two patients (cases 8 and 16). While the continuity of care was generally good when provided by the main CTC provider, serious errors arose when this one provider had an extended absence and other providers covered the patients. The providers indicated to the OIG during the onsite inspection that they had not fully reviewed the medical records due to time constraints and knowing that their CTC coverage was limited to one or two days until the regular provider returned. It is likely this contributed to the errors. These deficiencies are described further in the *Specialized Medical Housing* indicator.

Clinician Onsite Inspection

The medical leadership stated they had worked to make improvements to WSP since the OIG's Cycle 4 inspection report. This was apparent in the improvements noted in specialty services and chronic care of patients with heart disease. However, for the other patients in the specialized medical housing and for some patients with diabetes, the care would still improve with additional provider training.

At the time of the onsite inspection, there were no provider vacancies. The chief medical executive (CME) was concerned that this may not be the case in the future because of two issues. At the time of the onsite inspection, in order to improve recruitment and retention of physicians at certain institutions (not including WSP), CCHCS had planned a future salary increase. The CME opined that his physicians would possibly apply to other institutions, specifically two nearby, where the salary increase was planned. The other issue concerned mid-level providers. Both nurse practitioners and physician assistants had voiced dissatisfaction with salaries, which had not changed for many years. Two mid-level providers indicated plans to leave state service and return to community positions. Otherwise, provider morale was good. They felt strongly supported by the chief physician and surgeon (CP&S), with an excellent communication process in place with three daily meetings. All physicians, mid-level providers, and the CP&S started each day with a morning report to review the on-call events of the prior day and evening. This was followed by huddles in each of the health care areas by all primary care team members, custody, mental health, and dental. The third daily meeting was at the end of the day, during which the physicians shared important events and briefed the provider on call that evening.

Case Review Conclusion

For the most part, provider care at WSP was good. There were many significant provider deficiencies identified in the *Specialized Medical Housing* indicator for two patients. Those deficiencies strongly contributed to the *inadequate* rating for that indicator. The OIG clinicians, therefore, gave those deficiencies less weight in this *Quality of Provider Performance* indicator. Although the OIG clinicians rated this indicator *adequate*, there was opportunity for improved care.

12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(83.8%)

Overall Rating:
Adequate

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

The OIG clinicians reviewed 14 reception center arrival patients and 43 events. There were five deficiencies, two of which were significant (cases 52 and 54). The case review rating for the *Reception Center Arrivals* indicator at WSP was *adequate*.

Access to Care

Patients who arrived at WSP from county correctional facilities received timely and appropriate health care services. The reception center nursing staff adequately screened patients, completed physical assessments, noted durable medical equipment needs, and made appropriate follow-up referrals. All reception center arrivals were evaluated by a provider within one week at WSP, and all had timely dental and mental health screenings.

Missing documentation in patients' medical records causes the inability to appropriately determine current health care status and medical needs. One such significant deficiency occurred:

- In case 52, page 2 of the three-page medical transfer summary records from the county correctional facility was not scanned into the patient's electronic health record.

Medication Continuity

Reception center nurses consistently reviewed patients' current medications from county facilities and reconciled medication orders with a provider. Although new arrivals generally received medications continuously without interruption, the following significant deficiency was identified:

- In case 54, the diabetic patient arrived at WSP in the morning. The provider ordered a morning and an evening dose of insulin, but the patient did not receive any insulin doses until the following day.

Clinician Onsite Inspection

Annually, thousands of patients enter CDCR institutions through the WSP reception center. During the onsite visit, clinicians toured a well-organized reception area where nurses screened newly arrived patients. Each patient was scheduled with a medical provider at the diagnostics clinic for the initial history and physical examination during his first week after arrival, with primary care teams' follow-up in the yard clinics. The leadership at WSP stated that a priority was to carefully monitor the appointments and successfully avoid backlogs. These processes likely contributed to the dramatic improvements in operations for this reception center since the OIG's Cycle 4 inspection.

Case Review Conclusion

The OIG clinicians rated the *Reception Center Arrivals* indicator at WSP *adequate*.

Compliance Testing Results

The institution earned an *adequate* compliance score of 83.8 percent in the *Reception Center Arrivals* indicator, with *proficient* scores in the following tests:

- Inspectors sampled 20 reception center patients to ensure that they received timely health screenings upon arrival at the institution. All sampled patients had timely screenings (MIT 12.001).

- Reception center nursing staff timely completed, signed, and dated the assessment and disposition section of the initial health screening form for all 20 patients sampled (MIT 12.002).

- Inspectors sampled 20 reception center patients for required intake tests; all patients timely received all applicable intake tests (MIT 12.005).

- Providers timely reviewed and communicated intake test results for 19 of the 20 reception center patients who arrived at WSP during the sample period (95 percent). There was no evidence found that the provider communicated the results to one patient (MIT 12.006).

The following test scored in the *adequate* range:

- The institution timely offered or administered a valley fever skin test to 15 of the 20 sampled reception center patients (75 percent). Five patients consented to a valley fever test, but inspectors found no evidence WSP ever administered the test to them (MIT 12.008).

The following tests showed areas for improvement:

- Among 20 sampled patients who received an intake screening and whom the intake nurse referred to a provider, only 14 patients (70 percent) were seen timely by a provider. Six patients were seen between 3 and 25 days late (MIT 12.003). Furthermore, providers timely

completed reception center history and physical examinations within seven calendar days of arrival for only 14 of the same 20 sampled patients (70 percent). For six patients, the history and physical was completed 3 to 25 days late (MIT 12.004).

- The OIG sampled 20 reception center arrivals to ensure that each patient had a timely completed and properly documented TB skin test. While all 20 patients had their skin tests initiated within 72 hours of arrival, only 12 were properly conducted (60 percent). The following errors occurred among the other eight sampled patients (MIT 12.007):
    - Staff read six patients' TB test results prior to the minimum 48 hours.
    - One patient had a prior positive TB test but did not have a chest X-ray completed.
    - Another patient was administered a TB test, but staff did not document the time of administration; therefore, OIG inspectors were unable to confirm that the test result was read within the specific time range of 48 to 72 hours.

13 — *SPECIALIZED MEDICAL HOUSING*

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

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

Overall Rating:
Inadequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in an *adequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate.* The key factors were that the case review had a larger sample size, and the case review focused on the quality of care provided. As a result, the case review testing results were deemed a more accurate reflection of the appropriate overall indicator rating.

Case Review Results

The 16-bed CTC at WSP had 11 beds designated for patients with medical care needs and five for mental health patients. There was one negative pressure room, a space designed to minimize the spread of airborne infections. The OIG clinicians reviewed 101 events among eight CTC patients. This included 46 provider and 36 nursing encounters, some of which included several consecutive days of nursing care. The OIG clinicians identified 30 deficiencies, of which 13 were significant. While the nursing care was well done, multiple significant deficiencies in provider performance contributed to the *inadequate* rating.

Provider Performance

The provider performance was poor in the CTC. There were 20 deficiencies in the 46 provider encounters. Ten of the deficiencies were significant. Three of the significant deficiencies were in case 8. This patient had a new blood clot in his leg, and a lack of appropriate and careful medical record review contributed to this patient not receiving adequate care.

- In case 8, the provider demonstrated poor clinical judgment when this patient was scheduled for non-urgent surgery. The patient had had a recent blood clot in his legs two weeks earlier. The surgery should have been delayed until a time when the blood-thinning medications could more safely have been temporarily stopped. Fortunately, no harm came to the patient when the blood-thinning medication was held.

- Also in case 8, significant deficiencies occurred when a provider not familiar with the patient failed to adequately review the medical records and incorrectly concluded that the patient was receiving anticoagulation, when in fact it was being held because of surgery.

- In addition for case 8, the regular provider misinterpreted laboratory studies. A very elevated ferritin (iron) level was incorrectly interpreted as meaning the patient was iron deficient. The provider inappropriately prescribed iron supplements.

Notably, the ordinarily good continuity of provider care at WSP was absent in the CTC because the main CTC provider was away from the institution for much of the OIG's inspection period. Six of the significant provider deficiencies in this indicator occurred in case 16. This was a complex patient who had non-healing wounds for years. Nonetheless, the providers failed on multiple occasions to provide the care needed to reverse what was a significant underlying bone infection in his leg. All of the following deficiencies occurred in case 16:

- The CTC provider referred the patient to a vascular surgeon, but should have referred the patient to a surgeon or infection specialist for evaluation of possible osteomyelitis (bone infection).

- The same provider failed to recognize that a 10-day antibiotic course was likely insufficient, and failed to order diagnostic tests to determine if the osteomyelitis had resolved.

- Again, the same provider failed to review the orthopedic consult that was available in the electronic medical record. The provider failed to order the wound culture or the laboratory tests that the specialist recommended.

- The CTC provider failed to follow-up on the possibility of osteomyelitis. The provider again failed to carefully review the orthopedic surgery consult, which recommended further laboratory tests and a wound culture. The patient was lost to orthopedic follow-up after the provider's failure to follow the recommendations.

- The covering CTC provider wrote that the patient had osteomyelitis, but did not assess whether any confirmatory diagnostic testing had been performed (it had not), or if the patient had been adequately treated for osteomyelitis (he had not). The provider performed insufficient chart review and did not address all of the patient's ongoing medical conditions. Finally, the provider did not examine the wounds.

- The original CTC provider did not complete an adequate discharge summary. The provider's notes were scant and failed to discuss of the possibility of osteomyelitis, the unusual and hard to treat infection, or the limited antibiotics given while in the CTC. The provider did not discuss the abnormal X-rays or the plans for them. The scant and inadequate discharge summary reflected poor chart review and markedly increased the risk of a lapse in care.

Nursing Performance

Overall, the nursing staff at WSP provided adequate nursing care to patients in the CTC. Nurses conducted appropriate daily patient assessments that included physical examination, general status regarding activities of daily living, and re-assessment after providing an intervention such as pain medication. Nursing documentation was fairly thorough and generally included subjective information from the patient, changes in patient status, and provider contacts. The nursing wound care was well done and likely reflects quality improvement measures implemented following the OIG's Cycle 4 inspection report. There was one significant deficiency identified in the CTC patient cases reviewed.

- In case 4, the patient had a peripheral intravenous central catheter (PICC) line for a course of antibiotic therapy. After the antibiotic treatment course ended, CTC nurses did not perform regular daily maintenance by flushing with normal saline to ensure the patient's PICC line was not obstructed, per nursing protocol. The patient's PICC line was not given a maintenance flush until 16 days after the previous maintenance flush.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians found the CTC to be well staffed with experienced nurses and sufficient custody staff to support timely access for the provision of needed care to patients. Morning huddle occurred promptly at the designated time and location. Participants included the medical provider, mental health provider, nursing staff and supervisors, office support staff, and custody officers. Each patient was discussed with reports from numerous participants on the patient's current status, issues, treatment, and plan of care. The CTC huddle clearly demonstrated an appropriate practice model for the care team's morning reporting process. For the providers, the continuity of care was usually excellent in the CTC with one provider responsible for the day to day coverage. However, many of the significant deficiencies found during the OIG case review were during the main provider's absence from the institution. During the onsite interviews, the providers who temporarily covered the CTC indicated they did not fully review the medical records as they were only seeing the patient for one or two days. It is likely this cursory record review contributed to some of deficiencies found for otherwise providers capable of good care.

Case Review Conclusion

Due to significant deficiencies identified in provider performance regarding failure to provide the care needed, the OIG clinicians rated the *Specialized Medical Housing* indicator *inadequate*.

Compliance Testing Results

The institution scored an *adequate* 85.0 percent in the *Specialized Medical Housing* indicator, with *proficient* scores in the following three tests:

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

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

- Providers evaluated nine of ten sampled patients within 24 hours of admission and completed the required history and physical exam (90 percent). For one patient, the provider failed to document the time on the exam form; therefore, inspectors were unable to verify that the history and physical was completed within 24 hours of the patient's admission (MIT 13.002).

The final test in this indicator received an *inadequate* score:

- The OIG tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required three-day intervals. Providers timely completed SOAPE notes for only five of the ten sampled patients (50 percent). Five patients' provider notes were either one to two days late or not found at all (MIT 13.003).

14 — *SPECIALTY SERVICES*

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

Case Review Rating:
Adequate
Compliance Score:
Proficient
(86.8%)

Overall Rating:
Adequate

For this indicator, the OIG's case review and compliance review process 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*. While compliance testing just reached the proficient score, case review identified a number of significant deficiencies which kept the overall rating in the *adequate* range.

Case Review Results

The OIG clinicians reviewed 60 events related to specialty services, which included 45 specialty consultations and procedures and 15 nursing encounters. Ten deficiencies were found in this category, five of which were significant. The case review clinicians rated this indicator *adequate*.

Access to Specialty Services

While specialty services were generally provided within reasonable time frames for both routine and urgent services, significant delays in specialty follow-ups occurred in two cases. These placed the patients at risk for serious harm.

- In case 9, the provider requested an infectious disease follow-up visit in two weeks, but the appointment occurred in five weeks.

- In case 16, the provider requested a follow-up with the plastic surgery specialist in four weeks to determine if surgery was warranted. The patient did not have follow-up with the specialist at all.

Nursing Performance

Nursing care was adequate in offsite medical returns assessments, interventions, and documentation. The deficiencies in this category were related to poor communication. One telemedicine nurse deficiency was significant:

- In case 14, the telemedicine nurse failed to review the medical record, which showed the patient was sent to the hospital two days earlier for a possible heart attack. The patient left the hospital before important testing could be completed to see if his symptoms were from the heart or some other condition. This failure of the telemedicine nurse to review the record resulted in the cardiology consultant being unaware of a possible change in the patient's condition. Fortunately, no harm came to the patient.

Provider Performance

Provider performances related to specialty services were good. The case review process did not find any deficiencies in provider performance. Patients were referred appropriately and were seen in a timely fashion. Providers reviewed specialty recommendations thoroughly.

Health Information Management

Health information management deficiencies related to specialty services included reports that were scanned into the electronic medical record without a signature and reports that were not scanned into the electronic medical record. There were 63 events with seven deficiencies identified. The two significant deficiencies are listed below.

- In case 16, there was a failure to retrieve, scan, and review the dictated cardiology specialty report.

- Also in case 16, there was a failure to retrieve, scan, and review the specialty report from plastic surgery. There were orders from the specialist scanned under the "Other" tab in the electronic medical record, but there was no report regarding the full plan.

Clinician Onsite Inspection

While onsite, the leadership stated they had used the OIG's Cycle 4 inspection report to improve specialty services operations, especially in tracking appointments and scheduling. The OIG found a large improvement in the number of deficiencies for this indicator. However, the decrease in significant deficiencies for this indicator was only slightly improved.

Case Review Conclusion

The OIG clinicians found the overall processes in specialty services to be functioning well, and rated this indicator *adequate*.

Compliance Testing Results

The institution received a *proficient* compliance score of 86.8 percent in the *Specialty Services* indicator, with five tests earning high scores, as follows:

- For all 15 patients sampled, high-priority specialty service appointments occurred within 14 calendar days of the provider's order (MIT 14.001).

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

- WSP received a score of 100 percent when the OIG tested the timeliness of the denials of providers' specialty services requests for 20 patients (MIT 14.006).

- Providers timely received and reviewed the specialists' reports for 13 of 15 sampled patients (87 percent). For two patients, there was no evidence of a specialist's report in the electronic medical record. Although progress notes indicated that results were reviewed, both appointments occurred after the required time frame (19 and 29 days late) (MIT 14.002).

- Specialists' reports were timely reviewed by a provider following routine specialty service appointments for 12 of the 14 patients sampled (86 percent). For two patients, the specialty report was not reviewed by the provider at all (MIT 14.004).

One test in this indicator received an *adequate* score:

- When an institution approves or schedules a patient for specialty services appointments and then transfers the patient to another institution, policy requires that the receiving institution ensure a patient's appointment occurs timely. At WSP, 16 of the 20 sampled patients transferring in received their specialty services appointment within the required time frame (80 percent). Two patients received their appointments between 5 and 25 days late, and for the other two patients, there was no evidence in the medical record that an appointment was ever held (MIT 14.005).

The institution showed room for improvement in one test area:

- Among 18 patients sampled for whom WSP's health care management denied a specialty service, only ten patients (56 percent) received a timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternative treatment strategies. For three patients, the provider's follow-up visit occurred from 20 to 68 days late. For five patients, there was no provider follow-up to discuss the denial at all (MIT 14.007).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(78.6%)

Overall Rating:
Adequate

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

Compliance Testing Results

The institution received an *adequate* compliance score of 78.6 percent in the *Administrative Operations* indicator, with 12 tests scoring in the *proficient* range::

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

- The QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).

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

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

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter, and they contained all required summary reports and related

documentation. In addition, the drills included participation by both health care and custody staff (MIT 15.101).

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

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

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

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

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

- The OIG reviewed performance evaluation packets for WSP's 11 providers; WSP met all performance review requirements for ten of them. For one provider, the annual performance appraisal was not properly completed by the supervisor (MIT 15.106).

The institution showed room for improvement in the following areas:

- The institution had not taken adequate steps to ensure the accuracy of its Dashboard data. Although the institution provided substantial evidence of discussion of the methodologies used to conduct periodic data validation and the results of that data validation testing, the QMC meetings did not include discussion of methodologies used to train staff who collected Dashboard data and, therefore, WSP received a score of zero (MIT 15.004).

- The OIG inspected records for five nurses to determine if their nursing supervisors properly completed monthly performance reviews. Inspectors identified the following deficiencies for the five nurses' monthly nursing reviews (MIT 15.104):

    - The supervisor's review did not summarize aspects that were well done for any of the five nurses.

    - With two of the nurses, the supervisor did not discuss the findings of the review on a monthly basis.

- The pharmacist in charge did not have a system in place to ensure that the providers' Drug Enforcement Agency registrations did not expire, resulting in a score of zero on this test (15.110).

- WSP had three inmate deaths occur during the OIG's sample test period. The institution did not timely notify the CCHCS's Death Review Unit for one of the three deaths. As a result, the institution scored 67 percent on this test (MIT 15.103).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Two deaths occurred during the OIG's review period, both of which were unexpected (Level 1) deaths. The DRC was required to complete its death review summary report within 60 calendar days from the date of death and submit the report to the institution's CEO within seven calendar days thereafter. However, the DRC completed its report of the first death 4 days late (64 days after the death) and submitted it to WSP's CEO 13 days late. The second death review summary report was completed 192 days late (252 days after the death), but the report was submitted to WSP's CEO within the 7-day required time frame after the completion of the report (MIT 15.998).

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

RECOMMENDATIONS

The OIG recommends the institution develop a process to improve access to all radiology reports that have not been scanned into the eUHR since late 2015.

The OIG recommends WSP leadership provide training for providers on spending adequate time reviewing the medical records of unfamiliar patients, even when caring for the patient for a brief time. This is especially important for the more complex patients in the CTC.

POPULATION-BASED METRICS

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

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

Methodology

For population-based metrics, the OIG used a subset of HEDIS measures applicable to the CDCR patient population. Selection of the measures was based on the availability, reliability, and feasibility of the data required for performing the measurement. The OIG collected data using 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. WSP performed well with its management of diabetes compared to most state and national plans.

When compared statewide, WSP outperformed Medi-Cal in all five measures, but only outperformed or performed similarly to Kaiser Permanente in three of five diabetic measures selected. Kaiser, North region, scored 1 percentage point higher than WSP for patients under good control. Kaiser, both North and South regions, scored 2 percentage points better than WSP for diabetic blood pressure control. WSP scored 7 percentage points lower than Kaiser, South, for diabetic eye exams.

When compared nationally, WSP outperformed Medicaid, Medicare, and commercial health plans in all five diabetic measures. WSP outscored the United States Department of Veterans Affairs (VA) in two of the applicable measures (patients under poor control and diabetic blood pressure control) but scored lower than the VA in diabetic eye exams and diabetic monitoring.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, WSP performed poorly, outscoring only Medicaid. However, the 53 percent patient refusal rate negatively affected the institution's score. Nevertheless, WSP outperformed both Medicare and the VA regarding influenza shots for older adults. For administering pneumococcal vaccines to older adults, WSP scored much lower than Medicare and the VA.

Cancer Screening

With respect to colorectal cancer screening, WSP outperformed all other health care entities, statewide and national.

Summary

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

WSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	WSP Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So.CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**97%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**14%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**69%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)[6]	**81%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**74%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**42%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**83%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**50%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**85%**	-	79%	82%	-	63%	67%	82%

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

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

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

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

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

6. For this indicator, the entire applicable 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.

APPENDIX A — COMPLIANCE TEST RESULTS

Wasco State Prison Range of Summary Scores: 62.58% - 86.85%	
Indicator	**Compliance Score (Yes %)**
1–*Access to Care*	84.64%
2–*Diagnostic Services*	73.46%
3–*Emergency Services*	Not Applicable
4–*Health Information Management (Medical Records)*	69.96%
5–*Health Care Environment*	64.96%
6–*Inter- and Intra-System Transfers*	86.31%
7–*Pharmacy and Medication Management*	62.58%
8–*Prenatal and Post-Delivery Services*	Not Applicable
9–*Preventive Services*	71.37%
10–*Quality of Nursing Performance*	Not Applicable
11–*Quality of Provider Performance*	Not Applicable
12–*Reception Center Arrivals*	83.75%
13–*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	85.00%
14–*Specialty Services*	86.85%
15–*Administrative Operations*	78.60%

Reference Number	1–*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	17	8	25	68.00%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	20	5	25	80.00%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	35	0	35	100%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	34	1	35	97.14%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	5	3	8	62.50%	27
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?	4	0	4	100%	31
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	20	5	25	80.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	20	7	27	74.07%	3
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100%	0
Overall percentage:					**84.64%**	

Reference Number	2–*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	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 patient within specified time frames?	9	1	10	90.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.00%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	4	5	9	44.44%	1
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	6	0	6	100%	4
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	4	2	6	66.67%	4
Overall percentage:					**73.46%**	

3–*Emergency Services*

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

Reference Number	4–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated health care documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	16	4	20	80.00%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	14	6	20	70.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	19	1	20	95.00%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	18	1	19	94.74%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	0	24	24	0.00%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	20	5	25	80.00%	0
Overall percentage:					**69.96%**	

Reference Number	5–*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	11	0	11	100%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	11	0	11	100%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	9	2	11	81.82%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	6	4	10	60.00%	1
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	6	5	11	54.55%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.00%	1
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	9	2	11	81.82%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	9	11	18.18%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	10	1	11	90.91%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	7	4	11	63.64%	0
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	7	4	11	63.64%	0
Overall percentage:					**64.96%**	

Reference Number	6–*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	22	3	25	88.00%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	23	1	24	95.83%	1
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	8	3	11	72.73%	14
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	15	5	20	75.00%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	10	0	10	100%	0
Overall percentage:					**86.31%**	

Reference Number	*7–Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	16	3	19	84.21%	6
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	24	1	25	96.00%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	11	14	25	44.00%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	9	0	9	100%	11
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	21	4	25	84.00%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	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 over narcotic medications assigned to its clinical areas?	3	5	8	37.50%	3
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	2	8	10	20.00%	1
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	2	8	10	20.00%	1
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	4	3	7	57.14%	4
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	8	0	8	100%	3
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	6	2	8	75.00%	3
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100%	0

Reference Number	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	0	1	1	0.00%	0
7.111	Does the institution follow key medication error reporting protocols?	19	6	25	76.00%	0
Overall percentage:					**62.58%**	

8–*Prenatal and Post-Delivery Services*

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

Reference Number	9–*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	20	5	25	80.00%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	14	10	24	58.33%	1
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	14	16	30	46.67%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	24	1	25	96.00%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	22	3	25	88.00%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	10	8	18	55.56%	7
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	15	5	20	75.00%	0
Overall percentage:					**71.37%**	

10–*Quality of Nursing Performance*

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

11–*Quality of Provider Performance*

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

Reference Number	12–*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%	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%	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?	14	6	20	70.00%	0
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?	14	6	20	70.00%	0
12.005	For inmate-patients received from a county jail: Were all required intake tests completed within specified timelines?	20	0	20	100%	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?	19	1	20	95.00%	0
12.007	For inmate-patients received from a county jail: Was a tuberculin test both administered and read timely?	12	8	20	60.00%	0
12.008	For inmate-patients received from a county jail: Was a Coccidioidomycosis (Valley Fever) skin test offered, administered and read timely?	15	5	20	75.00%	0
Overall percentage:					**83.75%**	

Reference Number	13–*Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100%%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	9	1	10	90.00%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	5	5	10	50.00%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	1	0	1	100%	0
Overall percentage:					**85.00%**	

Reference Number	14–*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	15	0	15	100%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	13	2	15	86.67%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	12	2	14	85.71%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	16	4	20	80.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	10	8	18	55.56%	2
Overall percentage:					**86.85%**	

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	13	0	13	100%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	4	0	4	100%	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?	3	0	3	100%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	2	1	3	66.67%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	0	5	5	0.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100%	0
15.106	Are structured clinical performance appraisals completed timely?	10	1	11	90.91%	0
15.107	Do all providers maintain a current medical license?	13	0	13	100%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100%	1

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	0	1	1	0.00%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100%	0
Overall percentage:					**78.60%**	

APPENDIX B — CLINICAL DATA

Table B-1: WSP Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services — CPR	4
Emergency Services — Non-CPR	2
High Risk	4
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	21
Reception Center Transfers	3
Specialty Services	2
	54

Table B-2: WSP Chronic Care Diagnoses

Diagnosis	Total
Anemia	3
Anticoagulation	4
Arthritis/Degenerative Joint Disease	6
Asthma	7
COPD	7
Cancer	2
Cardiovascular Disease	16
Chronic Kidney Disease	7
Chronic Pain	15
Cirrhosis/End Stage Liver Disease	1
Coccidioidomycosis	2
Deep Venous Thrombosis/Pulmonary Embolism	6
Diabetes	15
Gastroesophageal Reflux Disease	8
Hepatitis C	21
Hyperlipidemia	16
Hypertension	27
Mental Health	13
Seizure Disorder	3
Sleep Apnea	1
Thyroid Disease	1
Total	**181**

Table B-3: WSP Event — Program

Program	Total
Diagnostic Services	141
Emergency Care	40
Hospitalization	49
Intra-system Transfers-In	3
Intra-system Transfers-Out	3
Not Specified	2
Outpatient Care	319
Reception Center Care	43
Specialized Medical Housing	99
Specialty Services	63
	762

Table B-4: WSP Review Sample Summary

	Total
MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	7
RN Reviews Focused	34
Total Reviews	61
Total Unique Cases	54
Overlapping Reviews (MD & RN)	7

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Wasco State Prison

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (5 per clinic) (35)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(19)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(24)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (11)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (25)	SOMS	• Arrival date (3–7 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (10)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *(20)*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (30)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (8)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (25)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, Annual Screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (20)	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *(20)*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services Access			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (19)	InterQual	• Review date (3–9 months) • **Randomize**
	 (1)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (11)	OIG Q:16.001	• All required performance evaluation documents
MIT 15.107	Provider licenses (13)	Current provider listing (at start of inspection)	• Review all
MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff ○ Providers (ACLS) ○ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (2)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

August 23, 2017

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Wasco State Prison (WSP) conducted from February 2017 to March 2017. 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
Roy Wesley, Chief Deputy Inspector General, OIG
Ryan Baer, Senior Deputy Inspector General, OIG
Scott Heatley, M.D., Ph.D., CCHP, Chief Physician and Surgeon, OIG
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