Roy W. Wesley
Inspector General

Office of the Inspector General

San Quentin State Prison
Medical Inspection Results
Cycle 5

February 2019

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
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Medical Inspection Results
Cycle 5

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FOREWORD

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

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

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. By the time of the Cycle 5 inspection of San Quentin State Prison, the Receiver had delegated this institution back to CDCR (on January 25, 2017).

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

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EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of San Quentin State Prison (SQ) in January 2019. The vast majority of our inspection findings were based on SQ's health care delivery between April 2017 and January 2018. Our policy compliance inspectors performed an onsite inspection in January 2018. After reviewing the institution's health care delivery, our case review clinicians performed an onsite inspection in October 2018 to follow up on their findings.

OVERALL RATING:

Adequate

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

Our clinician team reviewed 76 cases that contained 977 patient-related events. Our compliance team tested 93 policy questions by observing SQ's processes and examining 422 patient records and 1,263 data points. We distilled the results from both the case review and compliance testing into 14 health care indicators and have listed the individual indicators and ratings applicable for this institution in the *SQ Executive Summary Table* on the following page. Our experts made a considered and measured opinion that the overall quality of health care at SQ was ***adequate.***

SQ Executive Summary Table

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

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

Expert Clinician Case Review Results

Our expert clinicians reviewed cases of patients with many medical needs, and included a review of 977 patient care events.[1] The vast majority of our case review covered the period between July 2017 and December 2017. As depicted on the executive summary table on page *iv*, we rated 11 of the 14 indicators applicable to SQ. Of those 11 applicable indicators, we rated nine *adequate*, and two *inadequate.* When determining the overall adequacy of care, we paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal compliance or performance with processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs may be adequate. We identified inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- The providers felt supported by their chief physician and surgeon (CP&S) and their chief medical executive (CME). The providers expressed confidence in their leaders and agreed with the decisions their leaders made.

- In the cases we reviewed, the providers usually demonstrated in-depth knowledge of their patients and made accurate assessments and appropriate plans.

- The nurses reported that the nursing leadership was stable and supportive. The nurses felt that the chief nurse executive (CNE) was very hands-on and was continually implementing solutions to problems in nursing performance.

Program Weaknesses — Clinical

- Nurses performed poorly with recording medication administration. The nurses repeatedly recorded that medications were simply "unavailable," and subsequently failed to record when they later administered the medications. These errors rendered the medication administration records unreliable and often made it impossible for us to determine if patients received their medications.

- Reception center services were problematic. The nurses failed to intervene appropriately for patients with active medical problems and also did not provide patient education. The institution also had issues with medication continuity and timely access to provider follow-up for these patients who arrived from county jails.

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

Compliance Testing Results

Of the 14 health care indicators applicable to SQ, our compliance inspectors evaluated 11.[2] Of these, five were *adequate,* and six were *inadequate*. The vast majority of our compliance testing was of medical care that occurred between April 2017 and January 2018. There were 93 individual compliance questions within those 11 indicators, generating 1,263 data points that tested SQ's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] *Appendix A — Compliance Test Results* provides details of the 93 questions.

Program Strengths — Compliance

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

- The institution's medical records staff did well scanning non-dictated health care documents into patients' electronic medical records.
- SQ provided patients with timely high-priority and routine-priority specialty appointments. Additionally, SQ clinical staff then reviewed the resulting specialists' reports timely.
- The institution's nursing staff did well at ensuring that reception center patients received timely initial health screenings and tuberculosis (TB) testing.
- SQ staff ensured that patients received diagnostic services within ordered time frames.
- SQ providers timely reviewed laboratory and pathology results.

Program Weaknesses — Compliance

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

- SQ staff often failed to maintain medication continuity for chronic care patients, patients discharged from a community hospital, patients who were temporarily laid over at SQ, patients who transferred into the institution, and patients who transferred from a county jail.
- Staff at SQ did not consistently provide patients their tuberculosis (TB) medications within required time frames. The staff often failed to monitor their TB patients monthly. In addition, SQ often failed to perform annual TB screenings timely.

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

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

- The institution often failed to provide chronic care follow-up appointments within required time frames.

- Clinical staff did not consistently follow universal hand hygiene precautions before or after patient encounters.

- Nursing staff did not regularly inspect emergency response bags and crash carts.

Recommendations

The OIG recommends the following:

- The CNE should implement a comprehensive quality improvement program to improve the institution's delivery of reception center services because of the problems we found with nursing performance and provider appointments during this inspection.

- The CNE and the pharmacist in charge should implement quality improvement measures to ensure proper medication continuity for patients returning from offsite hospitals, arriving from county jails, and receiving chronic care medications. We found marked room for improvement in these areas during this inspection.

Population-Based Metrics

In general, SQ performed comparably to other health plans as measured by population-based metrics. In comprehensive diabetes care, SQ outperformed most state and national health care plans in the five diabetic measures. However, SQ scored lower than three health care plans for diabetic eye exams, diabetic blood pressure control, and HbA1c testing.

With regard to immunization measures, SQ scored higher than all other health care plans for influenza immunizations for both younger and older adults. However, the institution's score for pneumococcal immunizations was mixed, scoring higher than Medicare but lower than the U.S. Department of Veterans Affairs. SQ outperformed all reporting health care plans for colorectal cancer screening.

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INTRODUCTION

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

San Quentin State Prison (SQ) was the 35th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

ABOUT THE INSTITUTION

San Quentin State Prison is California's oldest and best-known correctional institution, established on the site currently known as Point San Quentin in July 1852. The walled prison houses mostly medium-security (Level 2) and reception center inmates, and has four large cell blocks (west, south, north, and east), one maximum-security cell block (the adjustment center), a central health care service building, a medium-security dorm setting, and a minimum-security firehouse. The institution houses all of California's condemned male inmates on death row.

The institution runs eight medical clinics where staff members handle non-urgent requests for medical services, and it treats patients needing urgent or emergency care in its triage and treatment area (TTA). San Quentin has a correctional treatment center (CTC) for inpatient services, which also includes a 40-bed psychiatric inpatient program. Patients are seen in the receiving and release (R&R) clinic upon arrival at San Quentin, and there is one specialty services clinic. SQ has been designated an intermediate (as opposed to basic) care prison; these institutions are predominately located in urban areas close to medical centers and specialty care providers likely to be used by a patient population with higher medical needs.

On August 16, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from CCHCS, as identified in the following *SQ Health Care Staffing Resources as of November 2017* table, SQ had one vacant executive leadership position, one vacant provider position, 5.6 vacant nurse supervisor positions, and 17.5 vacant nurse positions. At the time of the OIG's inspection, SQ had two nursing supervisors and seven nursing staff on extended leave.

SQ Health Care Staffing Resources as of November 2017

	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff**	Total
Authorized Positions	5.00	13.00	20.60	192.10	230.70
Filled by Civil Service	4.00	12.00	15.00	174.60	205.60
Vacant	1.00	1.00	5.60	17.50	25.10
Percent Filled by Civil Service	80.00%	92.31%	72.82%	90.89%	89.12%
Filled by Telemed	0.00	0.00	0.00	0.00	0.00
Percent Filled by Telemed	0.00%	0.00%	0.00%	0.00%	0.00%
Filled by Registry	0.00	1.73	0.00	7.51	9.24
Percent Filled by Registry	0.00%	13.31%	0.00%	3.91%	4.01%
Total Filled Positions	4.00	13.73	15.00	182.11	214.84
Total Percentage Filled	80.00%	105.62%	72.82%	94.80%	93.13%
Appointments in last 12 Months	1.00	2.00	6.00	37.00	46.00
Redirected Staff	0.00	0.00	0.00	0.00	0.00
Staff on Extended Leave^	0.00	0.00	2.00	7.00	9.00
Adjusted Total: Filled Positions	4.00	13.73	13.00	175.11	205.84
Adjusted Total: Percentage Filled	80.00%	105.62%	63.11%	91.16%	89.22%

*Executive Leadership includes Chief Physician & Surgeon.
**Nursing Staff includes Senior Psychiatric Technician/Psychiatric Technician.
^In Authorized Positions
Note: The OIG did not validate the SQ Health Care Staffing Resources and Filled Positions data.

As of December 4, 2017, the Master Registry for SQ showed that the institution had a total population of 4,037. Within that total population, 7.1 percent was designated as high medical risk, Priority 1 (High 1), and 12.3 percent was designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, the frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The following table illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

SQ Master Registry Data as of December 4, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	288	7.1%
High 2	495	12.3%
Medium	1,878	46.5%
Low	1,376	34.1%
Total	**4,037**	**100.0%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

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

Exhibit 1. Case Review Definitions

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

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

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

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

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

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

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

Patient Selection for Retrospective Case Reviews

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

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

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

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

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

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

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

Benefits and Limitations of Targeted Subpopulation Review

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

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

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

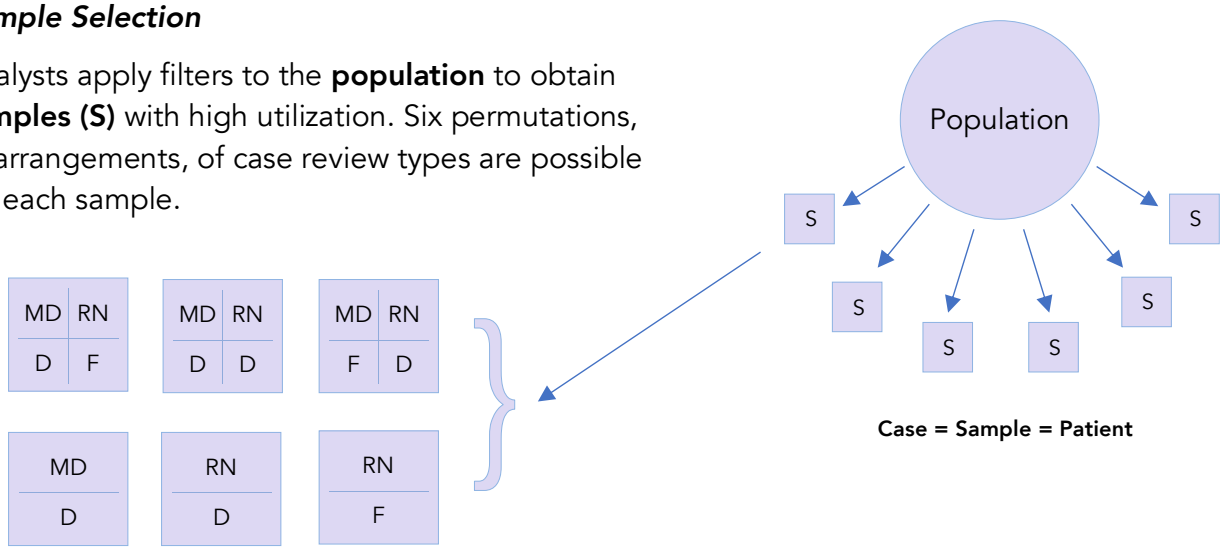
Case Review Sampling Methodology

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

Chart 1. Case Review Sample Selection

Sample Selection

Analysts apply filters to the **population** to obtain **samples (S)** with high utilization. Six permutations, or arrangements, of case review types are possible for each sample.



MD = Provider
RN = Registered Nurse
D = Detailed Review
F = Focused Review

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

Breadth of Case Reviews

As indicated in *Appendix B, Table B-1: SQ Sample Sets*, the OIG clinicians evaluated medical records for 76 unique cases. *Appendix B, Table B-4: SQ Case Review Sample Summary* clarifies that both nurses and physicians reviewed 19 of those cases, for 95 case reviews in total. Physicians performed detailed reviews of 25 cases, and nurses performed detailed reviews of 15 cases, totaling 40 detailed case reviews. Nurses and physicians also performed focused reviews of an additional 55 cases. These reviews generated 977 case review events (*Appendix B, Table B-3: SQ Event – Program*).

While the sampling method specifically pulled only six chronic care cases, i.e., three diabetes cases and three anticoagulation cases (*Appendix B, Table B-1: SQ Sample Sets*), the 76 unique cases sampled included 253 chronic care diagnoses, including 22 additional cases with diabetes (for a total of 25) (*Appendix B, Table B-2: SQ 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 OIG did assess for adequacy the overall operation of the institution's system and staff.

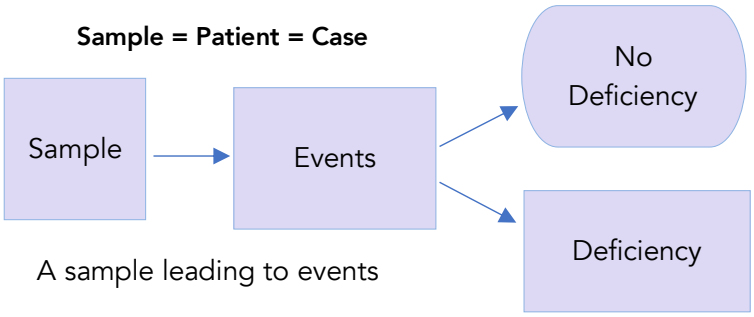
Case Review Testing Methodology

A physician, a nurse consultant, or both clinician inspectors review each case. The OIG clinician inspector can perform one of two different types of case review: detailed, or focused (see Exhibit 1, page 6, and Chart 1, previous page). As the OIG clinician inspector reviews the medical record for each sample, the inspector records pertinent interactions between the patient and the health care system. These interactions are also known as case review *events*. When an OIG clinician inspector identifies a medical error, the inspector also records these errors as case review *deficiencies.* If a deficiency is of such magnitude that it caused, or had the potential to cause, serious patient harm, then the OIG clinician records it as an *adverse deficiency* (see Chart 2, next page).

Chart 2. Case Review Testing and Deficiencies

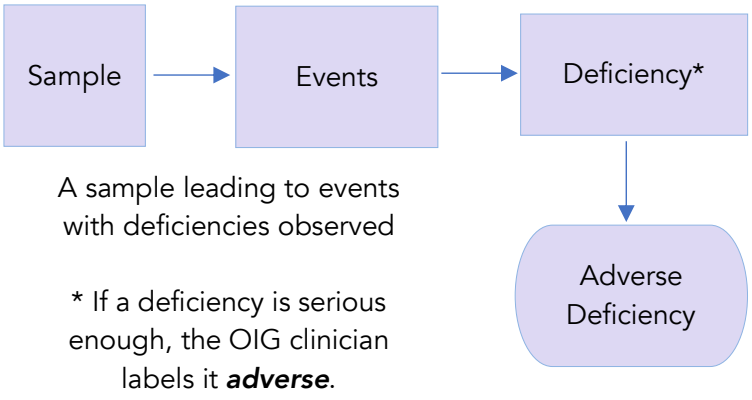
Case Review Testing

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



Deficiencies

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



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

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

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

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

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

Our registered nurse inspectors attained answers to 93 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 422 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 January 8, 2018, field registered nurse inspectors conducted a detailed onsite inspection of SQ's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,263 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 SQ's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

Scoring of Compliance Testing Results

After compiling the answers to the 93 questions for the 11 indicators for which compliance testing was applicable, the OIG compliance team derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 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 for this inspection when the rating differed for a particular quality indicator. In those instances, the inspection team assessed the quality indicator based on the collective ratings from both components. Specifically, the OIG clinicians and registered nurse inspectors discussed the nature of individual exceptions found within that indicator category and considered the overall effect on the ability of patients to receive adequate medical care.

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

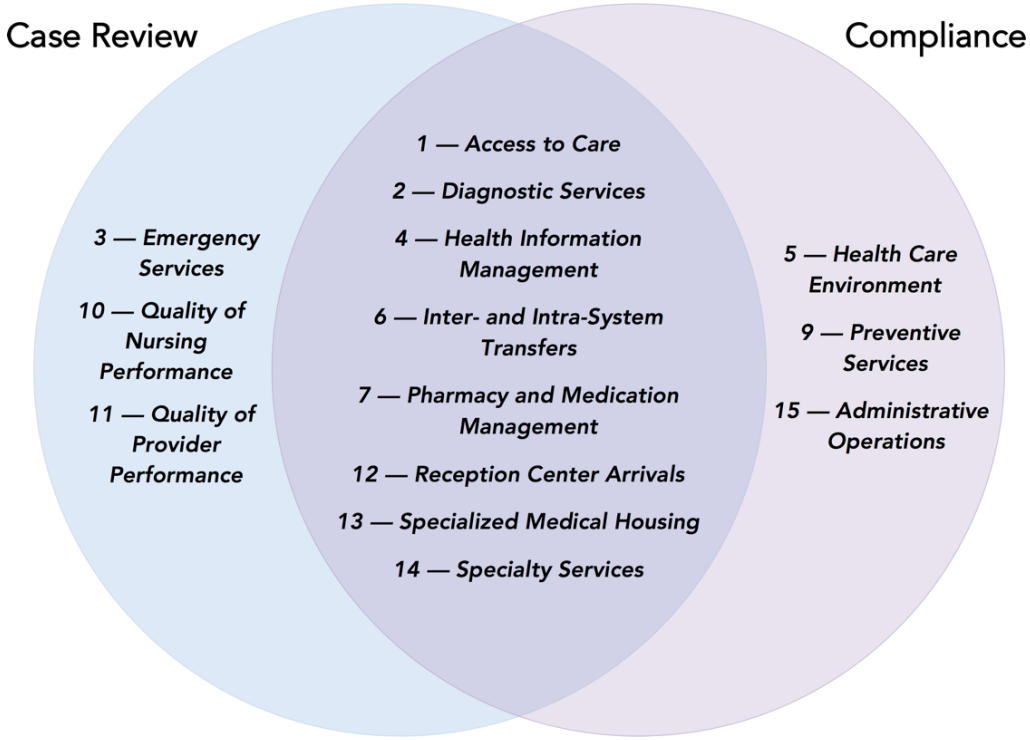
POPULATION-BASED METRICS

The OIG identified a subset of Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR patient population. To identify outcomes for SQ, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained SQ 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 OIG's case review and clinician teams use quality indicators to assess the clinical aspects of health care. The *SQ Executive Summary Table* on page *iv* of this report identifies the 14 indicators applicable to this institution. The following chart depicts their union and intersection:

Chart 3. Inspection Indicator Review Distribution



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

Summary of Case Review Results: The clinical case review component assessed 11 of the 14 indicators applicable to SQ. Of these 11 indicators, OIG clinicians rated nine *adequate* and two *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 20 were *adequate*, and five were *inadequate*. In the 977 events reviewed, there were 257 deficiencies, 82 of which were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

- In case 73, the patient tested positive for latent tuberculosis twice, and the staff started the patient on tuberculosis treatment. When the patient was hospitalized, a hospital physician did not have access to the abnormal tuberculosis tests and postulated that the patient may not have had tuberculosis. When the patient returned to the institution, the SQ provider prematurely decided that the patient no longer had a tuberculosis infection. The provider then prescribed an immunosuppressive medication, which could potentially reactivate or worsen tuberculosis and cause a public health problem. We notified SQ of this error, but the institution waited six weeks before stopping the risky medication and reevaluating the patient for tuberculosis. We also discuss this case in the *Quality of Provider Performance* indicator.

Summary of Compliance Results: The compliance component assessed 11 of the 14 indicators applicable to SQ. Of these 11 indicators, OIG inspectors rated five *adequate* and six *inadequate*. Each section of this report summarizes the results of those assessments, whereas *Appendix A* provides the details of the test questions used to assess compliance for each indicator.

1 — *ACCESS TO CARE*

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

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(67.6%)

Overall Rating:
Inadequate

In this indicator, the OIG case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance review resulting in an *inadequate* score. In our case review testing, we only found problems with nurse sick call access and delayed correctional treatment center (CTC) rounding. However, we found many more problems in our compliance testing, such as delays with chronic care follow-ups, provider appointments for patients transferring into the institution, provider follow-ups after specialty visits, and nurse-to-provider referrals. After considering the breadth of these problems with access and the risk of harm with these additional delays, we rated this indicator *inadequate*.

Case Review Results

The OIG clinicians reviewed 379 provider, nurse, specialty, and hospital events that required follow-up appointments and identified 51 deficiencies relating to *Access to Care*, 23 of which were significant (more likely than not to cause patient harm if not rectified). The case review rating for this indicator was *adequate*.

Provider-to-Provider Follow-up Appointments

The institution usually ensured that provider-ordered follow-ups occurred timely. Of the 149 provider-requested follow-ups reviewed, we found only one minor delay and one instance in which the provider did not see the patient.

Nurse Sick Call Access

The institution had difficulty ensuring timely access to sick call nurses. CCHCS policy requires that the nurse assess the patient the first business day after the nurse reviews the patient's sick call request form. We reviewed 45 cases with sick call requests and found delayed nurse sick call appointments in cases 3, 22, 26, 41, 49, 52, 53, 59, 63, 66, and 69. Although these delays occurred frequently, they usually occurred for sick call symptoms that were unlikely to represent urgent medical needs.

- In case 41, the nurse reviewed a sick call request for eye complaints but evaluated the patient two days late.

- In case 44, the patient requested medical services for constipation. Although staff scheduled a sick call appointment, the nurse did not see the patient.

- In case 49, the nurse reviewed a sick call request for right ankle pain and swelling. The nurse evaluated the patient two days late.

- In case 52, the nurse reviewed a sick call request for a bump on the left elbow but evaluated the patient one day late.

- In case 53, the nurse reviewed the sick call request for swollen, painful elbows but evaluated the patient one day late.

Nurse-to-Provider Referrals

We reviewed 24 instances in which a nurse referred the patient to a provider. The institution performed well providing timely appointments for these referrals. The appointments all occurred timely except in one case:

- In case 3, the patient had chest pain and shortness of breath. The nurse requested a provider follow-up within 14 days, but the appointment did not occur.

Nurse Follow-up Appointments

The institution usually scheduled nurse follow-up appointments timely. We found the following lapses in the 19 applicable events we reviewed:

- In case 3, the patient had another occurrence of chest pain and shortness of breath. The nurse ordered a follow-up within 48 hours, but the appointment did not occur until four days later (two days late).

- In case 23, the patient had a leg wound. The provider ordered the nurse to perform wound care every week for six weeks. The nurse wound care appointment occurred only once.

- In case 66, the patient's ear was clogged with wax causing hearing loss. The nurse ordered a follow-up appointment to irrigate the ears within 48 hours, but the appointment did not occur until five days later (three days late).

Provider Follow-up After Specialty Services

The institution did well scheduling follow-ups with the provider after a specialty appointment. We reviewed 127 encounters that required a provider follow-up and found two deficiencies, one of which was significant.

- In case 23, the patient returned from an orthopedic surgeon consultation. The patient was supposed to see his provider to follow up on the specialty consultation, but the institution did not schedule the appointment.

Intra-System Transfers

The institution successfully ensured transfer-in patients received timely provider appointments. Providers saw patients timely in all four transfer-in cases we reviewed.

Reception Center

The institution also effectively ensured patients arriving from county jails received timely provider appointments. The providers saw patients timely in five of the six reception center patients reviewed. We identified only one deficiency:

- In case 38, the provider saw the newly arrived patient eight days late.

Reception center nurses often failed to schedule an initial nurse care management visit for patients arriving from county jails as required by CCHCS policy. We discuss this problem further in the *Reception Center Arrivals* indicator.

Follow-up After Hospitalization

The providers consistently saw their patients timely after hospitalizations. We reviewed 22 instances in which the patient returned from a hospital or an outside emergency department and did not find any delays or missed appointments with the provider follow-up appointments.

Follow-up After Urgent/Emergent Care

SQ did well with follow-up after emergency care. We reviewed 20 urgent care visits after which the patient was sent back to housing and needed a provider follow-up. We identified only one deficiency:

- In case 38, the patient fainted and saw the provider in the urgent care setting. The provider requested a follow-up provider assessment in the urgent care clinic the next day. The nurse saw the patient instead of the physician.

Specialized Medical Housing

We reviewed six correctional treatment center (CTC) admissions and did not identify any deficiencies with the timeliness of the initial history and physical examinations. With regard to provider rounding, SQ providers performed poorly. Providers must record progress notes for their CTC patients every three days. However, SQ had a license waiver that allowed the providers to record progress notes every seven days if a provider assigned a patient a long-term-care (LTC) designation. The SQ CTC providers did not properly assign any of the reviewed patients LTC designations; 16 of the providers' rounding deficiencies were related to

SQ's errors in this regard. In addition to those errors, we found the following additional rounding deficiencies:

- In case 27, the patient had end-stage lung disease, and the provider often recorded progress notes in eight-day intervals during two months of the review period.
- In case 76, on one occasion, the provider did not see the patient until 11 days after the last provider visit.

Specialty Access and Follow-up

SQ performed acceptably with initial specialty access and follow-up appointments. We discuss performance in this area in the *Specialty Services* indicator.

Diagnostic Results Follow-up

The institution performed well in scheduling follow-ups providers requested after abnormal diagnostic results. We did not identify any deficiencies in this area.

Clinician Onsite Inspection

This cycle, the institution continued to have problems with CTC follow-up intervals. SQ medical leadership claimed that providers rounded on all the CTC patients daily and recorded progress notes within rounding intervals in accordance with CCHCS policy. The managers produced a copy of a license waiver that allowed providers to record progress notes every seven days for those patients designated LTC. The license waiver requires a provider to assign LTC designations to applicable patients to qualify for the longer follow-up intervals. SQ instead claimed that each CTC patient automatically met LTC qualifications after 30 days, with or without any provider designation. The OIG does not agree with the institution's interpretation or application of its CTC license waiver.

Case Review Conclusion

SQ generally provided sufficient access to meet its patients' needs. In this cycle, we found worsened performance with access to sick call nurses. Also, SQ providers continued to see their CTC patients at intervals that were inappropriately long because SQ did not properly utilize the LTC designation. Nonetheless, the worsened sick call access and prolonged follow-up intervals did not appear to place patients at risk of harm in the cases we reviewed. SQ performed reasonably well with regard to *Access to Care*, and our case reviewers rated this indicator *adequate*.

Compliance Testing Results

The institution performed in the *inadequate* range, with a score of 67.6 percent in the *Access to Care* indicator. The following tests earned scores in the *inadequate* range:

- We sampled 25 patients with chronic care conditions and found that 16 (64.0 percent) received timely provider follow-up appointments. Seven patients' follow-up appointments were one to 16 days late, and another patient's follow-up appointment was 381 days late. For one remaining patient, a provider's follow-up appointment did not occur at all (MIT 1.001).

- Among 25 patients sampled who transferred into SQ from other institutions and whom nurses referred to a provider based on their initial health care screening, 11 (44.0 percent) were seen timely. Thirteen patients received their provider appointments from two to 36 days late. One other patient received his appointment 140 days late (MIT 1.002).

- For 22 of the 32 patients sampled who submitted health care services request forms (68.8 percent), nursing staff completed a face-to-face encounter within one business day after reviewing the form. For six patients, nursing staff conducted patient encounters between one and two days late. For three patients, nursing staff did not document in Subjective, Objective, Assessment, Planning, and Education (SOAPE) format. For the remaining patient, we found no evidence that a face-to-face encounter occurred (MIT 1.004).

- Among nine health care services request forms sampled on which nursing staff referred the patient for a provider appointment, five patients (55.6 percent) received timely appointments. Four patients received their appointments from one to 10 days late (MIT 1.005).

- Eighteen of 29 sampled patients (62.1 percent) who received a high-priority or routine specialty service also received timely follow-up appointments with an SQ provider. Ten patients' follow-up appointments were one to 22 days late. One patient's follow-up appointment did not occur at all (MIT 1.008).

- Patients had access to health care services request forms at four of six housing units inspected (66.7 percent). Two housing units did not have a system in place for reordering health care services request forms and relied on medical staff or inmate clerks to acquire the forms for the unit housing (MIT 1.101).

One test received a score in the *adequate* range:

- We tested 25 patients discharged from a community hospital to determine whether they received a provider follow-up appointment at SQ within five calendar days of their return to

the institution. Twenty patients (80.0 percent) received a timely primary care provider follow-up appointment. Three patients received their follow-up appointments between one and three days late. For the remaining two patients, a provider follow-up appointment did not occur at all (MIT 1.007).

One test received a score in the *proficient* range:

- We sampled 32 health care services request forms submitted by patients across all facility clinics. Nursing staff reviewed all service request forms on the same day they were received (MIT 1.003).

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2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(75.9%)
Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 160 diagnostic events and found 14 deficiencies, three of which were significant. Of the 14 deficiencies, 12 related to health information management and two related to the non-completion of ordered tests. The case review rating for this indicator was *adequate*.

Test Completion

SQ usually completed laboratory tests in accordance with the providers' orders. However, we found two significant exceptions. While these types of errors were rare, they were significant because the providers needed the test results to determine the correct dosage of critical immunosuppressive medication.

- In case 26, the provider ordered laboratory staff to obtain levels of cyclosporine (medication used to suppress the patient's immune system to help preserve his kidney function) every two weeks. SQ's laboratory staff failed to perform these tests.

- Also, in case 26, the provider again ordered another cyclosporine level later in the same month. Again, laboratory staff failed to perform the test. These lapses resulted in poor monitoring for this critical medication and placed the patient at risk of harm of medication toxicity or progression of his kidney disease.

Health Information Management

SQ performed acceptably with processing diagnostic test reports. While we did not find any deficiencies in the retrieval of diagnostic studies, we did find delays in obtaining provider signatures in 12 of the cases. Fortunately, these delays did not significantly affect the quality of care.

- In case 28, the provider failed to sign an abnormally elevated prostate test result timely. An elevated test result could potentially indicate prostate cancer. Per CCHCS policy, providers should review and sign these results within two business days. Instead, the provider signed the report seven business days after the results were available.

Clinician Onsite Inspection

During our onsite inspection, SQ staff explained that the institution developed significant problems with support services, specifically the laboratory department, after our case review period concluded. The staff complained that there was insufficient oversight of the SQ diagnostics department in spring 2018. For months, providers could not obtain results of laboratory tests they ordered. They could not verify if the results were simply missing or if the tests were even performed. The laboratory supervisor claimed that there were compatibility and interfacing problems between the outside laboratory and the electronic health records system (EHRS), causing laboratory results to be unavailable for review. The institution resolved this by replacing some laboratory staff and assigning one staff member to check that every laboratory result was available in the EHRS. The SQ providers claimed the issue was resolved about six weeks before our onsite visit. Because these problems arose outside of our case review period, we did not identify these issues in our independent case reviews.

Case Review Conclusion

During the review period, the institution usually ensured that diagnostics tests were performed timely and correctly. We found that providers often reviewed and signed their laboratory reports late. Fortunately, these errors did not significantly affect the quality of care for their patients. We rated the *Diagnostic Services* indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 75.9 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Radiology services were timely performed for all 10 patients sampled (MIT 2.001). SQ providers then timely reviewed and signed the corresponding diagnostic services reports for six of the 10 patients (60.0 percent); for two patients, providers reviewed and signed reports five and 10 days late; and for the remaining two patients, inspectors found no evidence the providers signed their reports (MIT 2.002). Providers timely communicated test results to eight of the 10 patients sampled (80.0 percent). One patient received his result one day late. One other patient never received his results (MIT 2.003).

Laboratory Services

- Eight of 10 sampled patients (80.0 percent) received their provider-ordered laboratory services timely. Two patients received their laboratory services one and seven days late (MIT 2.004). The institution's providers reviewed and signed nine of the 10 resulting laboratory services reports (90.0 percent); one report was signed two days late (MIT 2.005). Finally, providers timely communicated the results to five of the 10 patients (50.0 percent). Five patients never received their results (MIT 2.006).

Pathology Services

- SQ clinicians timely received final pathology reports for nine of the 10 patients sampled (90.0 percent). For one patient's pathology report, there was no evidence found that the report was received (MIT 2.007). Providers timely reviewed and signed final pathology reports for seven of the nine patients (77.8 percent). For one patient, a provider reviewed the final pathology report one day late, and for the other patient, there was no evidence found that a provider reviewed the final pathology report (MIT 2.008). Providers timely communicated final pathology results to five of the nine sampled patients (55.6 percent). For four patients, the provider communicated pathology results one to 11 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, and advanced cardiac life support 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

We reviewed 43 urgent/emergent events and found 17 deficiencies with various aspects of emergency care. Most of these were minor documentation-related deficiencies. We identified one significant deficiency in case 30 that was related to provider performance. Overall, we assigned the *Emergency Services* indicator an *adequate* rating.

CPR Response

SQ staff responded to medical emergencies quickly and intervened correctly, including those cases that required CPR. We identified only minor delays in response time in the following cases:

- In case 5, the CPR response was appropriate. The first medical responders arrived at the scene quickly and started CPR immediately. However, the response time could have been further improved if custody staff had properly initiated CPR immediately in accordance with their training.
- In case 6, the first medical responders arrived at the scene but did not have immediate access to the patient's cell to provide emergency care to an unresponsive patient. Custody staff did not open the cell door until five minutes after the medical emergency system was activated.

Provider Performance

The providers generally saw patients with urgent and emergent conditions quickly and made accurate diagnoses and appropriate treatment decisions. While overall emergency provider performance was very good, we found one significant deficiency:

- In case 30, the kidney specialist sent the patient to the TTA because of dangerously high blood pressure. When the TTA staff rechecked his blood pressure, it had improved but was still seriously elevated. The TTA provider inappropriately discharged the patient back to his regular housing without any blood pressure monitoring and requested a lengthy one-week period before provider follow-up.

Nursing Performance

SQ nurses provided prompt emergency medical response and appropriate intervention. However, we identified a pattern of incomplete nursing assessment and documentation. Nursing leadership attributed the documentation deficiencies to the nurses' unfamiliarity with the EHRS.

We found that nurses failed to assess or monitor the patients' conditions in the TTA and did not document pertinent timelines or information in cases 2, 3, 7, 8, 10, 22, 26, 38, 73, 74, and 75. Although these deficiencies did not affect patient care, they demonstrated the nurses' failure to accurately depict clinical situations or the care they provided.

Emergency Medical Response Review Committee (EMRRC)

The SQ EMRRC properly analyzed emergency events, identified deficiencies, and made corrective action plans in 13 of the 14 emergent cases that the EMRRC and the OIG both reviewed. The only exception was as follows:

- In case 3, the EMRRC did not identify the nurse's incomplete and incorrect documentation of the emergency timeline and events.

Clinician Onsite Inspection

The TTA had ample space to provide medical care. There were two nurses present at all times. A provider was available during business hours six days a week. The providers voluntarily rotated from their clinics to the TTA on a weekly basis; the institution did not have a dedicated TTA provider. An on-call provider was available on Sundays and after hours.

When a medical emergency occurred, the TTA nurse and provider were expected to carry emergency response equipment to the scene via transport vehicle and perform basic life support immediately. Offsite ambulances responded directly to the emergencies in the yards to minimize their response times.

Case Review Conclusion

SQ TTA providers triaged emergency patients appropriately and made sound assessments and decisions. Nurses responded to emergencies quickly and intervened correctly. However, the nurses also made incomplete assessments and recorded inaccurate documentation. Fortunately, those problems were minor and did not affect the quality of care. SQ performed well with *Emergency Services*, and we rated this indicator *adequate*.

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4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(83.3%)

Overall Rating:
Adequate

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

In March 2017, which was during the OIG's testing period, SQ converted to the new electronic health record system (EHRS); therefore, most testing occurred in the EHRS, with a minor portion of the testing done in the electronic unit health record (eUHR).

Case Review Results

The OIG clinicians reviewed 977 events and found 31 deficiencies related to health information management, five of which were significant. The case review rating for this indicator was *adequate*.

Hospital Records

SQ usually did well with retrieving and processing outside hospital records. We reviewed 22 hospitalizations and outside emergency department events and identified only one significant deficiency.

- In case 24, the patient went to an offsite emergency department for a kidney stone and rupture of his urinary tract. SQ staff failed to retrieve the emergency department's physician progress notes regarding the patient's condition, forcing an SQ provider to call the hospital to discover the patient's diagnosis and care plan.

Specialty Services

The institution had difficulty obtaining specialty reports timely, forwarding them to providers for review and signature, and scanning them into the EHRS. We identified 14 deficiencies in this area, three of which were significant. We also discuss the institution's performance in this area in the *Specialty Services* indicator.

Diagnostic Reports

SQ performed acceptably with diagnostic report information. One problem we found was that providers often did not sign diagnostic reports timely. We also discuss this problem in the *Diagnostic Services* indicator.

Urgent/Emergent Records

SQ could improve with its documentation of emergency events. As in Cycle 4, the nurses continued to record inaccurate timelines and incomplete documentation. We also discuss performance in this area in the *Emergency Services* indicator.

Scanning Performance

Since Cycle 4, SQ's scanning performance improved. We identified only four minor deficiencies in cases 2, 12, 28, and 77. The transition to the EHRS likely reduced the number of errors as it removed a significant number of manually scanned documents.

Legibility

We found good legibility because the staff typed or dictated their notes into the EHRS.

Clinician Onsite Inspection

The providers reported that they believed they had sufficient access to needed health information. Occasionally, when the providers did not have the needed reports, they were able to successfully contact the utilization management nurse, the specialist, or the hospital to obtain the needed information.

Case Review Conclusion

In general, SQ performed satisfactorily with health information management. Scanning performance improved significantly since Cycle 4 with the transition to the EHRS. However, the institution still had difficulty reliably retrieving specialty reports. We found that providers helped to mitigate some of these problems by retrieving some of these reports themselves. Overall, the problems we identified did not place patients at increased risk of harm; thus, we rated the *Health Information Management* indicator *adequate*.

Compliance Testing Results

The institution performed in the *adequate* range with a score of 83.3 percent in the *Health Information Management* indicator. The following tests scored in the *proficient* range:

- The institution timely scanned all five sampled non-dictated health care documents into patients' electronic medical records (MIT 4.001).

- The institution's medical records staff timely scanned 18 of 20 sampled patients' discharge records into electronic medical records (90.0 percent); staff scanned two records one day late (MIT 4.004).

Two tests received *adequate* scores:

- Sixteen of 20 specialty service consultant reports sampled (80.0 percent) were scanned into the patients' electronic medical records within five calendar days. Four documents were scanned five to 10 days late (MIT 4.003).

- Among 25 sampled patients admitted to a community hospital, discharged, and then returned to the institution, SQ's provider timely reviewed 20 corresponding hospital discharge reports within three calendar days of the patient's discharge (80.0 percent). For one patient, the provider reviewed the hospital discharge report one day late. We found no evidence that SQ providers reviewed the remaining four patients' hospital discharge reports (MIT 4.007).

The OIG inspectors found room for improvement in the following test:

- SQ received a score of 66.7 percent on labeling and filing of documents scanned into patients' electronic medical records. For this test, once the OIG identifies 24 mislabeled or misfiled documents, the maximum points are lost, and the resulting score is zero. For this inspection, we identified eight mislabeled documents (MIT 4.006).

5 — *HEALTH CARE ENVIRONMENT*

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(50.9%)

Overall Rating:
Inadequate

This indicator addresses the general operational aspects of the institution's clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, the availability of both auditory and visual privacy for patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. The OIG rates this component entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit. There is no case review portion.

Compliance Testing Results

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

- Clinical health care staff at five of 12 applicable clinics (41.7 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. In four clinics, staff failed to mention disinfecting the examination table before starting shifts as part of their daily start-up protocol. In two clinics, staff did not properly package previously sterilized instruments (*Figure 1*). In addition, one of the two clinics did not routinely maintain the medical equipment sterilization log. In one clinic, we observed that staff did not replace the exam table paper between patient encounters (MIT 5.102).

Figure 1: Compromised sterility of medical equipment.

- Of the 12 clinics inspected, eight had operating sinks and sufficient quantities of hand hygiene supplies in examination areas (66.7 percent). In four clinics, patient restrooms did not have disposable hand towels (MIT 5.103).

- We observed clinician encounters with patients in 12 clinics. Clinicians followed good hand hygiene practices in only three clinics (25.0 percent). At nine clinic locations, clinicians failed to wash their hands before or after patient contact or before applying gloves (MIT 5.104).

- The non-clinic bulk medical supply storage areas did not meet the supply management process and support needs of the medical health care program, earning SQ a score of zero on this test. Upon interview at the time of inspection, the warehouse manager expressed

challenges to collecting and delivering bulk and heavy items placed on the top shelves without a functioning forklift. In addition, the manager reported the lack of training for clinical health care staff on following the supply management protocols in place (MIT 5.106).

- We found that six of the 12 clinics (50.0 percent) followed adequate medical supply storage and management protocols. In six clinics, one or more of the following deficiencies were observed: medical supplies were not clearly identifiable; disinfectant agents were stored in the same area with medical supplies; and staff reported that there was no system in place to replenish medical supplies on a regular basis (MIT 5.107).

- Only seven of 12 clinic locations (58.3 percent) met compliance requirements for essential core medical equipment and supplies. The remaining five clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included a nebulization unit, a functioning ophthalmoscope and charging station, hemoccult cards and developer, lubricating jelly, and tongue depressors. In addition, an oto-ophthalmoscope did not have a calibration sticker, and tongue depressors were found in an unsanitary container (MIT 5.108).

- Only four of 12 clinic exam rooms observed (33.3 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. In eight clinics, one or more deficiencies were observed: a clinician desk drawer handle was broken, an exam room did not provide reasonable visual privacy during patient encounters; confidential patient records were accessible to inmate-porters; examination tables had torn vinyl covers; and an examination room did not have adequate space for a clinician to perform a patient examination (MIT 5.110).

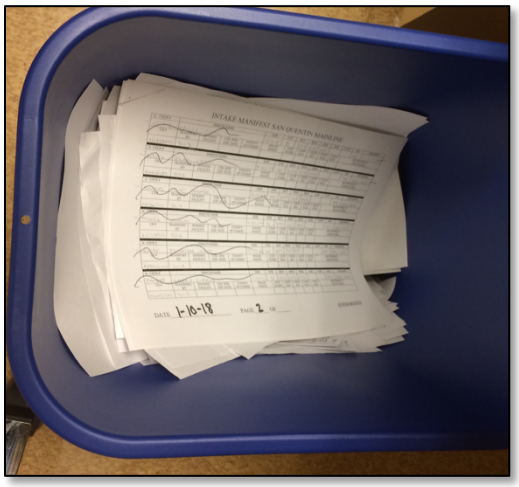

Figure 2: Confidential documents easily accessible to inmate porters.

- We examined emergency response bags (EMRBs) and crash carts to determine if SQ staff inspected them daily and inventoried them monthly, and if they contained all essential items. EMRBs were compliant in only one of the 10 clinical locations where they were stored (10.0 percent). In nine locations, one or more deficiencies were observed: one CPR micro-mask was missing; documentation did not indicate an inventory of the EMRB had been completed in the previous 30 days; and the crash cart was missing minimum levels of medical supplies (MIT 5.111).

One test received a score in the *adequate* range:

- Ten of the 12 clinics examined (83.3 percent) were appropriately disinfected, cleaned, and sanitary. In two clinics, restroom cleaning logs were not maintained daily (MIT 5.101).

Two tests received scores in the *proficient* range:

- Health care staff at all 12 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).

- Clinic common areas at 11 of the 12 clinics (91.7 percent) had environments conducive to providing medical services. The location of the blood-draw services in one clinic compromised patients' auditory privacy (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 does not score this question.

- We 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. When we interviewed health care managers, they did not identify any significant concerns. At the time of our medical inspection, SQ had several significant infrastructure projects underway, which included H-Unit Dorm 1EOP conversion, creating temporary modular space for telepsychiatry, and building a new telepsychiatry space. These projects started in winter 2017, and the institution estimated that they would be completed by 2020 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(64.3%)
Overall Rating:
Adequate

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

In this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in an *inadequate* score. Our case review testing found that the nurses performed well assessing patients transferring into and out of SQ and assessing those returning from an offsite hospital. Compliance testing found problems with medication continuity for patients transferring into the institution. Our compliance tests also showed that nurses did not identify pending specialty appointments on the transfer-out forms and did not send medication administration records with the patients' transfer packages. Further analysis revealed that most of the errors we identified were minor and did not place patients at increased risk of harm. Even with the most concerning issue, medication continuity, we found the institution usually did well with continuity for critical transfer medications. Taking all these factors into consideration, we rated this indicator *adequate*.

Case Review Results

We reviewed 30 inter- and intra-system transfer cases. These included 22 hospitalization and outside emergency room cases, each of which resulted in a transfer back to the institution. We found 10 deficiencies, one of which was significant. The case review rating for this indicator was *adequate*.

Transfers In

Receiving and release (R&R) nurses at SQ performed initial health screenings for the four patients we reviewed who transferred into SQ from other CDCR institutions. These patients

usually received their medications timely and saw an SQ provider within appropriate time frames. While each of these transferring-in patients eventually received appropriate transfer care, we identified errors with the initial follow-up appointments. The institution may use the following examples for quality improvement:

- In case 31, the R&R nurse incorrectly recorded the transferring-in patient as a reception center patient. This error resulted in an erroneous order for an unnecessary medical history and physical exam to occur within seven days.

- In case 32, the patient arrived with multiple medical problems. The R&R nurse erroneously recorded that the patient did not require a referral to a medical provider. Fortunately, a different nurse scheduled the provider appointment timely.

- In case 73, the R&R nurse failed to enter orders for a provider appointment for the newly arrived patient with chronic medical conditions. Fortunately, a different provider caught the error, entered an order for follow-up, and evaluated the patient timely.

- Also, in case 73, the R&R nurse intended for the patient to follow up with a clinic nurse within five days. The nurse again failed to enter orders for the appointment, which did not occur.

Transfers Out

SQ nurses successfully facilitated the transfer of care of patients transferring from SQ to other CDCR institutions. We reviewed the records of four of these patients. In these cases, the nurses performed satisfactory face-to-face evaluations before patient transfers and appropriately sent health care information, medications, and health care equipment along with the patients to the receiving institution. We also identified that in each case, the R&R nurse did not check the patients' vital signs before their departure.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during any transfer. We reviewed 22 of these cases, and SQ generally ensured that its patients did not suffer lapses in care when they returned from the hospital. Compared to Cycle 4, SQ also improved in retrieving and scanning community hospital reports within acceptable time frames. There was one significant deficiency with regard to medication continuity. While most patients received their hospital discharge medications appropriately, SQ should use the following example for quality improvement:

- In case 27, the patient returned from the hospital after suffering respiratory failure from severe lung disease. When he returned to SQ, medical staff admitted him to the CTC. However, because the pharmacist was unavailable, the patient did not receive most of his

medications until the following day, including critical inhaler medications. We also discuss this error in the *Pharmacy and Medication Management* indicator.

Clinician Onsite Inspection

The SQ nurses we interviewed were familiar with the intra-facility transfer process and ensured that medications transferred with patients when they moved to their new housing units within the institution. The R&R nurses were knowledgeable of the processes for transferring patients in and out of the institution. An RN and licensed vocational nurse (LVN) worked together to complete health screenings, perform evaluations, review health care information, reconcile medications, and identify any health care needs for newly arrived and transferring-out patients. An Omnicell (automated medication dispensing cabinet) was recently installed in the R&R, so patients arriving after business hours had better access to needed medications. The TTA RN evaluated patients returning from offsite hospitals and notified the provider of the hospital findings and recommendations. The TTA RN also reconciled the provider orders to ensure continuity of care.

Case Review Conclusion

SQ performed satisfactorily with regard to the *Inter- and Intra-System Transfers* indicator. Although we found some problems that the institution can target for quality improvement, the cases we reviewed demonstrated sufficient care during the transfer processes overall. We rated this indicator *adequate*.

Compliance Testing Results

The institution scored in the *inadequate* range for this indicator with a score of 64.3 percent, earning *inadequate* scores on the following tests:

- Of the 25 sampled patients who transferred into SQ, 15 had existing medication orders that required nursing staff to issue or administer medications upon their arrival. Ten of these 15 patients (66.7 percent) received their medications without interruption. Five patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).

- We sampled 20 patients who transferred out of SQ to other CDCR institutions to determine whether SQ identified scheduled specialty service appointments on the patients' health care transfer forms. Nursing staff correctly listed pending specialty appointments for 11 of the 20 sampled patients (55.0 percent). Staff failed to list nine patients' pending specialty services on the health care transfer form (MIT 6.004).

- SQ scored zero percent when the OIG tested three patients who transferred out of SQ during the onsite inspection to determine whether the patients' transfer packages included required medications and related documentation. All transfer packages did not have the corresponding medication administration record (MAR) (MIT 6.101).

Two tests received scores in the *proficient* range:

- Nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day patients arrived for all 25 patients who transferred into SQ from other CDCR institutions (MIT 6.001).

- Nursing staff timely completed the assessment and disposition sections of the screening form for all 20 applicable patients who transferred into SQ (MIT 6.002).

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7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(35.0%)
Overall Rating:
Inadequate

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

Case Review Results

We evaluated 57 events related to medications and found 20 deficiencies, 14 of which were significant. We identified significant deficiencies in cases 9, 20, 26, 27, 37, 38, 39, 41, 73, and 76. Many of the deficiencies were related to SQ's transition to the EHRS as medication nurses made errors when documenting medication administration in the new system. Overall, medication errors were widespread, and the case review rating for this indicator was *inadequate*.

Medication Administration and Continuity

When medications were available, nurses administered them timely. However, when medications were not available, nurses usually did not take any action to resolve the problem. The systemwide failure of nurses to intervene when medications were unavailable resulted in lapses in medication administration and increased risk of harm.

SQ had problems maintaining medication continuity in several areas. We found the institution had difficulty with medications for reception center patients arriving from county jails, those returning from a community hospital, and those receiving regular chronic care medications. We found these errors in cases 9, 19, 20, 22, 37, 38, 39, 41, 73, 76, and the following:

- In case 26, the patient had kidney disease that required specialized treatment with cyclosporine, a critical medication that suppresses the body's immune system. The provider ordered the medication to start immediately. However, the institution did not administer the medication until three days later. Furthermore, the institution failed to deliver a sufficient supply of the medication, which resulted in the patient taking less than the prescribed dosage.

- In case 27, the patient had severe lung disease. We found that the institution failed to provide the patient with multiple medications, including several critical medications and

inhalers for his lung disease. On one occasion, the patient was prescribed potent steroid medications, but the institution failed to provide them. The sudden withdrawal of the medication placed the patient at risk for worsening lung disease. On another occasion, the patient returned from the hospital with severe chronic obstructive pulmonary disease (COPD) and was admitted to the CTC. The patient did not receive most of his medications, including an inhaler, the same day because the pharmacist was unavailable. We also discuss this last error in the *Inter- and Intra-System Transfers* indicator.

Pharmacy Errors

When we identify medication errors, it is often difficult for us to determine if the error originated in the pharmacy since pharmacy staff usually do not record notes in the EHRS. With these limitations, we found only one pharmacy processing delay in case reviews:

- In case 37, the provider ordered sevelamer (medication to lower phosphate levels in patients with chronic kidney disease). The pharmacy delivered it two hours late, and the patient did not start the medication until the following day.

Clinician Onsite Inspection

When we asked about the numerous lapses in medication administration we identified in the case reviews, the pharmacy supervisor displayed screenshots of pharmacy dispense times and dates for the medications that were missing. The CNE explained the perceived lapses in medication continuity were a result of nurses' unfamiliarity with the new electronic health record system (EHRS) during the case review period. The nurses often recorded that medications were unavailable and subsequently failed to record when they later administered those medications. This practice rendered the medication administration records (MARs) unreliable. The CNE claimed they corrected this problem in January 2018 when they provided training to the medication nurses. The institution also installed an automated drug delivery system in the reception center in March 2018 to prevent delays in medication administration.

Case Review Conclusion

After SQ transitioned to the EHRS, the institution's medication management was poor. The nurses' improper recording practices rendered the MARs unreliable and sometimes made it impossible to determine if and when patients received their medications. Newly arrived patients also had problems getting their medications timely, causing breaks in continuity. SQ performed poorly with regard to medications, and we rated the *Pharmacy and Medication Management* indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 35.0 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

For this sub-indicator, the institution received an *inadequate* score of 45.0 percent. The following tests scored in the *inadequate* range:

- SQ administered chronic care medications timely to four of 23 applicable sampled patients (17.4 percent). For 17 patients, nursing staff did not refill KOP medication before exhaustion. One patient did not receive appropriate counseling for missed doses. For the remaining patient, medication was not made available timely (MIT 7.001).

- SQ timely administered or delivered newly prescribed medication to 18 of 25 sampled patients (72.0 percent). Seven patients received their medications one to 31 days late (MIT 7.002).

- SQ timely provided hospital discharge medications to 14 of the 24 patients we sampled (58.3 percent). Nine patients received their medications one to four days late; and for one patient, one dose of his hospital discharge medication was given late (MIT 7.003).

- Inspectors reviewed files of 20 sampled patients who recently arrived at SQ from a county jail and identified seven patients who needed to be reissued non-PRN medications upon their arrival. Of the seven applicable patients sampled, two patients received their medications timely (28.6 percent). Three patients received one or more of their medications from one dose to one day late. We found no evidence that the remaining two patients received or refused medications (MIT 7.004).

- Nursing staff administered medications without interruption to only one of the 10 patients (10.0 percent) who were on the way from one institution to another and had a temporary layover at SQ. For the other nine patients, there was no evidence that nursing staff administered the patients' medications (MIT 7.006).

One test earned a score in the *adequate* range:

- SQ ensured that 21 of the 25 sampled patients who transferred from one housing unit to another (84.0 percent) received their 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).

Observed Medication Practices and Storage Controls

The institution scored 37.5 percent in this sub-indicator, with the following tests scoring in the *inadequate* range:

- The institution employed adequate security controls over narcotic medications in one of the 11 applicable clinics and medication line locations where narcotics were stored (9.1 percent). In 10 clinics, one or more deficiencies occurred: the narcotics logbook showed on multiple occasions that a controlled substance inventory was not performed by two licensed nursing staff; the narcotic medications did not remain under double-lock control; a licensed nurse did not counter-sign the narcotics log for the disposal of a controlled substance; the medication nurse removed stock in a manner that did not allow a spontaneous count; and we found a discrepancy during our own physical count of SQ narcotic medications (MIT 7.101).

- SQ safely stored non-refrigerated, non-narcotic medications in seven of 12 applicable clinic and medication line storage locations (58.3 percent). In five locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; oral and topical medications were not properly separated when stored; employees' personal food items were found stored long term in the medication supply area; and multi-use medication was not labeled with the date it was opened (MIT 7.102).

- The institution safely stored refrigerated, non-narcotic medications in only two of 10 clinics and medication line storage locations (20.0 percent). At eight locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy refrigerated medications; the refrigerator temperature was not kept within the acceptable range; and the medication refrigerator was unlocked (MIT 7.103).

- We observed the medication preparation and administration processes at eight applicable medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at three locations (37.5 percent). At five locations, not all nursing staff washed or sanitized their hands when required, such as prior to putting on gloves or before re-gloving (MIT 7.104).

- Nursing staff at only one of eight inspected medication line locations (12.5 percent) employed appropriate administrative controls and followed appropriate protocols during medication preparation. In seven locations, one or more of the following deficiencies were observed: patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather; the medication nurse did not always ensure that patients swallowed direct-observation therapy (DOT) medications; the medication nurse was not able to verbalize the appropriate reporting process of medication errors; and the medication nurse did not appropriately administer medication as ordered by the provider.

We also observed SQ medication nurses not following manufacturers' guidelines related to the proper administration of insulin to diabetic patients. Those guidelines require medication nurses to visually verify insulin dosage units prior to patients' self-administering and to disinfect previously opened multi-use insulin vials before withdrawing and administering medication (MIT 7.106).

One test received a score in the *proficient* range:

- SQ nursing staff at seven of eight sampled locations (87.5 percent) employed appropriate administrative controls and protocols when preparing patients' medications. At one medication line location, nursing staff did not have a system in place to validate if newly received medications were correct through reconciling those medications with the physician's orders (MIT 7.105).

Pharmacy Protocols

SQ scored 20.0 percent in this sub-indicator, with the following tests earning *inadequate* scores:

- In its main pharmacy, the institution did not follow general security management. The narcotics locker was unlocked when not in active use (MIT 7.107).

- In its main pharmacy, SQ did not properly store non-refrigerated medication. The main pharmacy stored these medications beyond manufacturers' guidelines (MIT 7.108).

- The institution's pharmacist in charge (PIC) did not properly account for narcotic medications or review monthly inventories of controlled substances stored in SQ's clinics and medication line storage, resulting in a score of zero on this test. The staff responsible for completing the medication area inspection checklist (CDCR Form 7477) did not sign the form (MIT 7.110).

- We examined 25 medication error follow-up reports and monthly medication error statistics reports generated by the PIC. None of the PIC's 25 reports were timely or correctly processed. More specifically, the PIC did not submit the monthly medication error statistics reports for all the months sampled to the chief of pharmacy services. In addition, two of the 25 medication errors were determined to be a Severity Level 4[5] error. The PIC did not provide any evidence that a Sentinel Event/Adverse Event Form and an incident summary were submitted to the chief of pharmacy services as required by CCHCS policy. As a result, SQ scored zero on this test (MIT 7.111).

[5] A medication error that resulted in the need for treatment or hospitalization. California Correctional Health Care Services, Inmate Medical Services Policies & Procedures, Volume 3, Chapter 7.5, May 2017.

The following test received a *proficient* score:

- In its main pharmacy, the institution properly stored and monitored non-narcotic medications that required refrigeration (MIT 7.109).

Non-Scored Tests

- In addition to the OIG's testing of reported medication errors, inspectors follow up on any significant medication errors found during compliance testing to determine whether SQ properly identified and reported errors. The OIG provides those results for information purposes only. At SQ, the OIG did not find any applicable medication errors (MIT 7.998).

- The OIG interviewed patients housed in isolation units to determine whether they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. Fourteen of 15 applicable patients interviewed indicated they had access to their rescue medications. One inmate indicated that he notified his provider that he did not need the medication. Upon notification, SQ's provider discontinued the medication (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

As SQ does not have female patients, this indicator does not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

This indicator assesses whether the institution offered or provided various preventive medical services to patients. These include cancer screenings, tuberculosis screenings, and influenza and 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
(66.6%)

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 scored in the *inadequate* range for this indicator at 66.6 percent. The following four tests scored in the *inadequate* range:

- We examined the health care records of 25 patients who were on tuberculosis (TB) medications during the inspection period. Fourteen patients received all their required doses of TB medications (56.0 percent). SQ failed to provide the required doses of TB medications to 11 patients. Eleven patients missed one or more scheduled doses and did not receive timely provider counseling for missed doses (MIT 9.001).

- We reviewed SQ's monitoring of 25 sampled patients who received TB medications and noted that the institution was compliant for 16 of them (64.0 percent). For nine patients, the institution either failed to complete monitoring at all required intervals or failed to scan the monitoring form into the patient's electronic medical record in a timely manner (MIT 9.002).

- We sampled 30 patients at SQ to determine whether they received a TB screening within the last year and during the month of their birth. SQ timely screened nine of the 30 sampled patients (30.0. percent). The institution failed to screen 21 patients during their birth month (MIT 9.003).

- We tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from chronic conditions; eight of the 15 sampled patients (53.3 percent) received the required vaccinations. The institution failed to document whether seven patients had received or refused a pneumovax vaccination within the past five years or whether they had received a hepatitis vaccination (MIT 9.008).

Two tests received *proficient* scores:

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

- SQ offered colorectal cancer screenings to 24 of the 25 sampled patients subject to the annual screening requirement (96.0 percent). One patient did not have a normal colonoscopy within the last 10 years and was not offered a colorectal cancer screening within the previous 12 months (MIT 9.005).

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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 onsite, such as outpatient, inpatient, urgent/emergent, patient transfers, care coordination, and medication management. The key focus areas for evaluation of nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions, and accurate, thorough, and legible documentation. Although the OIG reports nursing services provided in specialized medical housing units in the *Specialized Medical Housing* indicator, and those provided in the TTA or related to emergency medical responses in the *Emergency Services* indicator, this *Quality of Nursing Performance* indicator summarizes all areas of nursing services.

Case Review Results

We reviewed 340 nursing encounters, of which 191 were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN follow-up visits. In all, there were 110 deficiencies identified related to nursing care, 19 of which were significant. We found the most significant nurse deficiencies in the outpatient and reception areas. Nonetheless, the SQ nurses usually provided timely and appropriate care, and the case review rating for this indicator was *adequate*.

Nursing Assessment

We evaluated 73 cases with nursing encounters in various clinical areas. SQ nurses generally performed satisfactory assessments. The assessment deficiencies we found were usually minor and included the lack of focused examination in the affected areas of the body, insufficient subjective information, failure to obtain measurements such as vital signs and weight, and incomplete review of the patient's health record. These deficiencies were frequent, occurring in 29 of the 73 applicable cases, usually occurring with reception center and sick call nurses. Nonetheless, despite these errors, most nurses satisfactorily addressed their patients' most critical medical needs so that patients were not placed at significant risk of harm.

Nursing Intervention

SQ nurses usually intervened appropriately for their patients. However, we found that nurses sometimes failed to address their patients' medical symptoms or requests. These deficiencies

included failures to intervene correctly, to refer the patient to the provider when needed, to inform the provider of test results or abnormal findings, to implement nursing protocol orders, or to provide patient education. We found a serious pattern of these deficiencies with reception center nurses and occasionally with outpatient nurses.

Nursing Documentation

Nurses generally recorded good documentation that corroborated their delivery of good nursing care. Most documentation deficiencies we found were minor and occurred during RN sick call encounters and emergency medical events. These documentation errors did not affect the quality of care the nurses provided. We also discuss emergency nursing documentation in the *Emergency Services* indicator.

Nursing Sick Call

We evaluated 45 cases with sick call requests for appropriateness and timeliness of nursing triage, assessment, and intervention. These cases included 109 RN sick call encounters. Nurses timely reviewed sick call requests and assessed patients with urgent needs. However, we found delayed sick call appointments in 12 of the 45 cases, and in one of these cases, the appointment did not occur at all. In those cases, the patients' symptoms did not suggest dangerous problems, and the delays did not place the patients at significant risk of harm. We also discuss these delays in the *Access to Care* indicator.

When sick call nurses evaluated their patients, their performance was satisfactory. The nurses properly addressed their patient's most critical needs. However, we did find numerous incomplete nursing assessments and insufficient interventions for their patients' non-critical needs, but those errors usually did not place patients at increased risk of harm. The SQ nursing department should consider the following deficiencies for quality improvement purposes:

- In case 3, the patient submitted a sick call request for chest pain, dizziness, shortness of breath, and numbness of both hands. The nurse contacted the housing unit to bring the patient to the clinic, but the patient never arrived. The nurse took no further action to locate the patient with symptoms of a possibly serious heart problem. The following day, another nurse saw the patient but failed to examine the patient's lungs and hands, and did not perform an electrocardiogram (EKG, a test that records the electrical signals of the heart). The nurse did not notify the provider of the patient's symptoms and inappropriately scheduled a routine provider appointment in two weeks. When the nurse assessed the patient four days later, the patient continued to have the same symptoms and stated his heart was also pumping fast when he was lying down. Again, the nurse performed a cursory assessment and failed to notify a provider of the patient's ongoing symptoms. SQ staff sent the patient to an offsite hospital for further evaluation 12 days later. Fortunately, the patient did not have a heart attack.

- In case 23, the nurse did not properly triage the patient's sick call request. The patient had fallen and complained of rib pain. The patient's description of his medical symptoms warranted urgent medical attention, but the nurse inappropriately waited an additional day to see the patient.

- In case 49, the patient submitted a sick call request complaining his feet were swollen with open sores and his medication was not working. The nurse instructed the patient to continue using the medication and that he would see the provider at the next appointment, which was more than two months away. Four days later, the patient complained of a swollen and painful ankle. The nurse instructed the patient to elevate his legs and told him that a provider appointment would be scheduled within 14 days. The nurse did not schedule any provider appointment, and instead only scheduled a nurse appointment. Fortunately, a scheduler later corrected the error, and a provider saw the patient timely.

Urgent/Emergent Care

Nurses provided timely emergency medical response and good intervention. We found problems with emergency documentation, but those errors did not compromise the patients' care. We discuss this performance further in the *Emergency Services* indicator.

Care Management

Nurse care managers should assess and monitor patients with chronic conditions or who are at risk of developing serious health complications. Nurse case managers should intervene as needed to reach their patients' treatment goals. SQ nurses were reliably involved in primary prevention services only when new patients arrived at the institution. Otherwise, nurse care managers only helped care for patients if a provider ordered such intervention. Nurse care managers seldom made early interventions such as patient monitoring, review of medication compliance, and patient education. In our opinion, SQ nurse care managers did not sufficiently care for patients with chronic conditions. They should care for all chronic care patients, with or without a provider's order.

Specialized Medical Housing

CTC nurses provided satisfactory care. They did demonstrate room for improvement with performing focused assessments and initiating nursing care plans for newly identified medical problems. We discuss these issues further in the *Specialized Medical Housing* indicator.

Intra-System Transfers

The TTA nurses sufficiently assessed and ensured continuity of care for patients returning from the hospital. The R&R nurses performed acceptably in most aspects of the transfer processes. Nonetheless, they did have difficulty correctly ordering nurse and provider follow-ups for newly arrived patients. The nurses also neglected to check the vital signs of patients who transferred out

of the institution before their departure. We discuss these issues further in the *Inter- and Intra-System Transfers* indicator.

Reception Center

Reception center nurses performed poorly. Although they completed initial health screenings for newly arrived patients, they had significant difficulty evaluating and intervening properly for patients with urgent medical problems. The nurses also failed to comply with reception center policy and often failed to schedule initial nurse care management visits or provide patient education. The *Reception Center Arrivals* indicator includes further details on these issues.

Offsite Specialty Services Returns

SQ nurses provided good care and ensured provider follow-up for patients returning from specialty services. However, the nurses often failed to ensure that specialty reports arrived with their patients and failed to contact specialty providers to inquire about missing findings and recommendations. We described these issues further in the *Specialty Services* indicator.

Clinician Onsite Inspection

As in Cycle 4, SQ nurses continued to enjoy stable and supportive nursing leadership. The chief nurse executive (CNE) was very involved with quality improvement projects. She acknowledged the various nursing issues identified in the cases we reviewed and had already implemented several solutions. The nursing supervisors were visible in their areas, and the staff nurses showed enthusiasm while performing their jobs. The morning huddles were usually well organized and ran smoothly. The nurses reported no communication barriers among the health care team.

Case Review Conclusion

There were some areas that SQ should target for quality improvement. Nurses can improve their assessment skills, such as asking pertinent information and performing sufficient focused examinations. Sick call nurses can evaluate their patients' symptoms more quickly to improve their compliance with policy. Reception center nurses did not perform satisfactorily, and they need to learn to address abnormal findings they find during the initial health screening and make appropriate interventions. The institution's nurse care management program appeared to be in its infancy, and most chronic care patients did not receive satisfactory care management. Nonetheless, as a whole, SQ nurses provided appropriate nursing care. We rated this indicator *adequate* overall.

11 — *QUALITY OF PROVIDER PERFORMANCE*

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

OIG physicians alone assess provider care. 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

We reviewed 224 medical provider encounters and identified 40 deficiencies related to provider performance, 18 of which were significant. Of the 25 detailed cases we reviewed, we rated 20 cases *adequate* and five cases *inadequate*. The case review rating for this indicator was *adequate*.

Assessment and Decision-Making

In general, the SQ providers demonstrated good assessment and diagnostic skills. They usually made accurate assessments and diagnoses. However, we did find several instances in which providers made questionable or superficial assessments:

- In case 10, the patient had chronic liver disease and developed a skin rash. He submitted a sick call request for an oral antifungal medication that was potentially toxic to the liver. The provider prescribed the potentially dangerous medication without seeing the patient.

- In case 26, the patient had autoimmune kidney disease requiring treatment with cyclosporine (immunosuppressant medication). The provider had questions regarding the proper dosing of the medication but failed to follow through with the plan to contact the nephrologist, potentially exposing the patient to inappropriate treatment of the kidney disease.

- In case 73, the patient had conflicting tuberculosis test results. The provider inappropriately ignored two abnormal test results when the provider prematurely decided that the patient no longer had a tuberculosis infection. The provider then prescribed the patient an immunosuppressive medication that could potentially reactivate or worsen an existing tuberculosis infection and cause a public health problem. We notified SQ of this error, but the institution waited six weeks before stopping the risky medication and reevaluating the patient for tuberculosis.

Review of Records

The providers usually reviewed specialty and diagnostics reports with satisfactory depth and acted upon those results correctly. The following example was an exception to that good performance:

- In case 28, the patient's blood test strongly suggested prostate cancer. The provider did not review the report timely and did not notify the patient of the possibility of prostate cancer.

Provider Continuity

SQ had problems with provider continuity that we did not see in Cycle 4. SQ staff explained that one provider retired and another provider moved out of state. Patients saw multiple different providers, which contributed to lapses in care.

- In case 26, the patient had kidney disease and was taking cyclosporine. The patient needed to have his cyclosporine drug levels tightly monitored and titrated. A covering provider failed to keep the drug levels at the specialist-recommended goals.

- In case 28, the patient's blood test strongly suggested prostate cancer. Multiple providers were involved in the patient's care. One provider failed to review the test result and failed to act properly on it. When a repeat test returned even more elevated than the first, a second provider also failed to act appropriately and did not notify the patient. Later in the case, a third provider also failed to act on the patient's persistently elevated prostate cancer test.

Chronic Care

The providers provided good care to anticoagulation and Hepatitis C patients. Additionally, they also correctly treated their diabetic and hypertensive patients. The following examples were unusual exceptions:

- In case 17, the patient had uncontrolled diabetes, and the provider failed to order a follow-up appointment after a laboratory test showed worsening blood sugar control.

- In case 30, the patient had high blood pressure and kidney disease. Controlling his blood pressure was essential to minimizing the progression of kidney disease. Over the six-month review period, the provider did not take appropriate actions to lower the patient's blood pressure.

Specialty Services

The providers made proper referrals when their patients needed specialty services. The providers ordered the referrals correctly and requested appropriate time frames, except in the following cases:

- In case 75, the provider documented a plan to refer the patient to a neurologist for seizure diagnosis and management but failed to do so.
- In case 17, the provider documented a plan to refer the patient to the endocrinologist for uncontrolled diabetes but failed to do so. Three months later, the provider discovered that the patient had not seen the specialist and submitted the proper order and request at that time.

Emergency Care

The providers performed well in the emergency care setting. The TTA and on-call providers triaged patients accurately and appropriately. Providers responded promptly to medical emergencies and brought supplies to initiate basic life support or advanced cardiac life support protocols. We found only one provider deficiency in emergency care, which was due to a lack of documentation:

- In case 10, the provider did not record a progress note in the TTA for the patient with a finger laceration.

Specialized Medical Housing

Providers usually offered good clinical care for their patients in the correctional treatment center (CTC). However, the providers often did not record progress notes within time frames that were in accordance with CCHCS policy and with CTC licensing requirements. The *Access to Care* and *Specialized Medical Housing* indicators include more details about these issues.

Clinician Onsite Inspection

We observed the morning huddle meetings in several clinics. Although each clinic followed a standardized huddle script, the quality and effectiveness of the meetings in the different clinics were inconsistent. In some clinics, the patient discussions were superficial. Providers and nurses were not familiar with their patients, and the discussions focused on simple scheduling. In other clinics, the care team demonstrated in-depth knowledge of their patients, which was consistent with CCHCS's complete care model of health care delivery.

The providers explained that morale declined precipitously when several of SQ's providers left the institution. At the time of the onsite inspection, the CME lamented the scarcity of quality candidates and reported inability to fill two persistent provider vacancies. The CME attributed the continuing provider vacancies to the inflated cost of living in the San Francisco Bay Area and

increased private sector market competition. Furthermore, CCHCS reduced SQ's allotment of provider positions and simultaneously increased the institution's patient population. These decisions resulted in the institution's increased responsibility to care for more patients with fewer providers.

In an attempt to meet these additional responsibilities, the CME hired temporary registry providers and utilized CCHCS primary care telemedicine services, with mixed results. The CME conveyed trepidation regarding the CCHCS telemedicine providers due to the unpredictable quality and quantity of their work. SQ medical leaders also expressed reservations regarding the inability to effectively supervise telemedicine providers located remotely. In spite of these serious concerns, the CME decided to increase SQ's utilization of telemedicine providers due to the continuing dearth of qualified candidates for the onsite provider positions.

During the provider interviews, all providers expressed extreme frustration with SQ's laboratory performance in the spring of 2018, which was after our case review period. The laboratory often failed to perform tests providers ordered. Even when the laboratory performed the tests, the results were frequently unavailable because laboratory staff had not manually entered the results into the EHRS. We discuss these problems further in the *Diagnostic Services* indicator.

Morale worsened since Cycle 4. However, the providers expressed that rapport among their colleagues remained excellent. They also conveyed unwavering support for their managers. Within a brief period, the longtime CME assumed the role of acting CEO, the chief physician and surgeon (CP&S) promoted to the CME position, and another physician colleague promoted to the CP&S position. The providers credited their leaders as an important reason most of them stayed even as morale plummeted due to insufficient staff and problems related to the transition to the new EHRS.

Case Review Conclusion

In comparison to Cycle 4, SQ's provider performance declined. The frequency of provider deficiencies doubled. The institution transitioned to the EHRS, received an increased patient population, and lost several experienced physicians. These factors contributed to diminished provider productivity, insufficient staffing, poor continuity, worsened morale, and an increased rate of errors. Despite their noticeable decline in performance during this inspection, SQ providers were still able to meet their patients' most critical medical needs, and as a whole, they rarely placed their patients at undue risk of harm. We rated the *Quality of Provider Performance* indicator *adequate*.

12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating: *Inadequate*
Compliance Score: *Adequate (77.0%)*
Overall Rating: *Inadequate*

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

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *inadequate* rating and the compliance testing resulting in an *adequate* score. Our case review testing found that the reception center nurses performed poor assessments for patients transferring into SQ from county jails. The nurses also did not refer their patients for nurse care management appointments. SQ had trouble maintaining medication continuity for these patients. Our compliance testing found that patients often received their history and physical examinations late. The institution scored extremely poorly in medication continuity for reception center patients. Because the institution's poor performance in these areas placed their patients at increased risk of lapsed care, we rated this indicator *inadequate*.

Case Review Results

We reviewed six reception center cases, in which there were 18 events. In those six cases, we identified 12 deficiencies, nine of which were significant. The case review rating for this indicator was *inadequate*.

SQ demonstrated various problems with nursing performance, medication management, and access to care. The following are a few examples of the issues we found with SQ's reception center care:

- In case 23, the patient arrived from a county jail with a chronic bone infection, an open wound, and a recent jaw fracture. The R&R nurse did not assess the patient's wound and did not obtain an order for wound care from the provider. The nurse scheduled an RN appointment the next day for wound care, but the appointment did not occur. The patient also complained of jaw pain, and the nurse inappropriately requested a dental appointment in 60 days instead of an urgent dental appointment.

- In case 37, the patient arrived with multiple chronic diseases and was on hemodialysis. The R&R nurse did not check for the presence of or the condition of the patient's vascular access on the left forearm used for hemodialysis. The nurse administered the TB skin test but did

not read the result after the injection. A repeat skin test was not performed until more than one month later. Additionally, the patient did not receive his chronic medications timely. The nurse recorded that the medications were not available, and took no action to obtain the required medications.

- In case 38, the patient had chronic kidney disease and hypertension and was on hemodialysis. When he arrived at SQ, his blood pressure was very elevated. The nurse did not inquire whether the patient took his medications that day, did not re-check the patient's blood pressure, and did not inform the provider of the abnormal blood pressure. The nurse also failed to check if the patient was scheduled for dialysis that day. Further, the institution did not maintain medication continuity. The provider ordered the patient's blood pressure medication to start the same day the patient arrived, but the nurse did not administer the medications until the following day. The provider appointment occurred one week late, and the provider did not order a renal diet for the patient who was on dialysis.

- In case 39, the patient had hypertension, diabetes, and chronic kidney disease. The patient's blood sugar level was elevated when he arrived at the institution. The R&R nurse did not ask if or when the patient ate or took his medications. The nurse did not check the patient for symptoms of hyperglycemia (high blood sugar) and did not notify a provider of the elevated blood sugar level. The patient also did not receive one of his blood pressure medications timely.

In addition to the various problems illustrated in these cases, we also found that SQ nurses had difficulty complying with some aspects of the reception center policy. CCHCS policy requires a nurse care management visit within seven days of arrival at the reception center. It also requires R&R nurses to provide newly arrived patients information on accessing health care services, patients' rights, and the complete care model for health care services delivery. In all six of the cases we reviewed, the R&R nurses did not schedule an initial nurse care management visit and failed to provide patients with health care services information.

Clinician Onsite Inspection

SQ processed newly arrived patients from county jails in the R&R. An RN and a licensed vocational nurse (LVN) assessed the patients for medical, dental, and mental health issues. The nurses were knowledgeable about their responsibilities to screen patients for symptoms of tuberculosis and valley fever, perform vision tests, and order the correct diagnostic tests, preventive services, medications, and provider follow-ups. During our onsite inspection, the CNE stated that SQ had not fully implemented nurse care management at the institution. When we asked how the nurses provided patient information on accessing health care services, the R&R nurse displayed a patient orientation handbook, which had all the necessary information on health care services.

Case Review Conclusion

The R&R nurses were adept in completing initial health screenings and orders for newly arrived patients from county jails. However, the nurses had problems performing focused assessments when needed or making appropriate interventions for patients with abnormal findings. SQ also had difficulty ensuring medication continuity and complying with reception center health care policy regarding initial nurse care management visits and patient education. Because of these problems, we rated the *Reception Center Arrivals* indicator *inadequate.*

Compliance Testing Results

The institution scored in the *adequate* range for this indicator at 77.0 percent. The following five tests scored in the *proficient* range:

- We sampled 20 reception center patients to ensure they received a timely health screening upon arrival at the institution. Nursing staff conducted timely screenings for 18 of those (90.0 percent). For two patients, nurses did not document a complete set of vital signs. Nursing staff did not document one patient's respiratory rate, and for another patient, the nursing staff failed to document a blood sugar reading (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 nine patients sampled (MIT 12.002).

- Nurses referred seven patients who arrived at SQ from county jails to see a provider. Providers saw six patients timely (85.7 percent). A provider saw one patient 14 days late (MIT 12.003).

- We sampled 20 reception center patients for required intake tests; 19 of them (95.0 percent) timely received all applicable intake tests. One patient's specimen collection was not performed timely (MIT 12.005).

- We sampled 20 reception center arrivals to ensure that each patient had a timely completed and properly documented TB skin test. All 20 patients had their TB tests timely administered, read, and documented (MIT 12.007).

One test received an *adequate* score:

- After ordering intake tests for reception center arrivals, providers timely reviewed and communicated the test results to 15 of 20 patients sampled (75.0 percent). For two patients, providers did not communicate the results timely. For the remaining three patients, we found no evidence that providers communicated the results at all (MIT 12.006).

Two tests earned *inadequate* scores:

- Providers timely completed reception center history and physical examinations within seven calendar days of the patient's arrival for 11 of 20 sampled patients (55.0 percent). For nine patients, providers completed the history and physical between 10 and 22 days late (MIT 12.004).

- The institution timely administered the coccidioidomycosis (valley fever) skin test to three of the 20 sampled reception center patients (15.0 percent). The institution offered the test between one and 28 days late for nine patients. For the remaining eight patients, we found no evidence that a coccidioidomycosis skin test was offered, administered, or timely read (MIT 12.008).

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13 — *SPECIALIZED MEDICAL HOUSING*

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(75.0%)
Overall Rating:
Adequate

Case Review Results

We reviewed six CTC admissions, which included 58 provider events and 30 nursing events. Each provider and nursing event consisted of up to one month of provider rounds and several consecutive days of nursing care. We identified 27 deficiencies, eight of which were significant. The case review rating for this indicator was *adequate*.

Provider Performance

SQ had one dedicated provider who saw patients in the 10 beds in the CTC. Providers must record progress notes for their CTC patients every three days. However, SQ had a license waiver that allowed the providers to record progress notes every seven days if a provider assigned a patient a long-term-care (LTC) designation. The SQ CTC provider did not properly assign any of the reviewed patients LTC designations. We found 16 provider errors in this inspection.

The SQ medical managers interpreted the license waiver such that newly admitted patients in the CTC were seen every three days for the first 30 days, then patients automatically turned into LTC patients, regardless of whether a provider made such a designation. The OIG does not agree with SQ's interpretation because the LTC designation is a clinical decision; only a provider can determine if a CTC patient is stable enough to warrant the LTC designation. We also discuss this problem in the *Access to Care* indicator.

These rounding deficiencies did not negatively affect the quality of care. Usually, the CTC provider made correct assessments and sound decisions. We found only three sporadic provider deficiencies in cases 27, 74, and 75. These were likely simple, isolated provider oversights. The institution can use the following examples for quality improvement purposes:

- In case 27, the provider did not review the medical record thoroughly and ordered several medications that nurses had already administered to the patient. Although one nurse caught several of the duplicates, the patient still received some of the duplicate medications. Fortunately, no harm occurred from this error.

- In case 75, the provider planned to refer the patient to a neurologist for seizures but failed to place the order or initiate the referral.

Nursing Performance

Overall, CTC nurses performed sufficient assessments and provided appropriate and timely interventions for their patients. We found eight nursing deficiencies, but these errors did not constitute any pattern that suggested that poor care was widespread. The institution should use the following examples for quality improvement purposes:

- In case 74, the patient was admitted to the CTC for swelling of the entire body and chronic pain. The patient had an inguinal (groin) hernia, which made it difficult for him to walk around the institution. The CTC nurse did not perform a physical examination at the time of admission. At a minimum, the nurse should have performed a focused examination of the pertinent body areas related to the patient's presenting problems. When the patient was discharged from the CTC, the nurse did not complete a nursing discharge summary and did not provide discharge instructions to the patient.

- In case 76, the patient was admitted to the CTC for severe psoriasis (a chronic skin disease in which the skin cells build up and form scales and itchy, dry patches). The patient also had uncontrolled diabetes. At the time of admission, the CTC nurse asked the patient about symptoms of tuberculosis, and the patient reported he had fever, cough, chills, night sweats, and excessive fatigue. These symptoms were all suggestive of tuberculosis, but the nurse did not refer the patient to the provider for further medical evaluation.

- Also in case 76, the patient had a rash in the groin area, which persisted and later resulted in an abscess. The CTC nurses did not regularly check the patient's skin and incorrectly reported that the patient's skin was improving. In addition, the nurses failed to initiate an individualized patient care plan for diabetes. The patient's blood sugar level continued to rise, and a provider eventually started him on insulin.

Clinician Onsite Inspection

During the onsite inspection, eight of the 10 CTC medical beds were filled. The CTC had one dedicated provider, who was unavailable during our onsite inspection. Although we found problems with the provider's rounding intervals, the CME claimed that the provider conducted daily patient rounds and simply did not record those encounters. Between shifts, the nurses gave verbal reports and used a paper tracking system to communicate patient care needs among the staff. Custody staff was present to provide immediate access to the patients. SQ staffed the CTC each shift with an RN, an LVN, and additional certified nursing attendants (CNAs) as needed. The nurses conveyed sufficient knowledge of the CTC procedures and their individual responsibilities.

Case Review Conclusion

Clinically, the patients received appropriate medical care in SQ's CTC. We found only sporadic provider deficiencies. The nursing care was mostly satisfactory. We found some serious errors

with nursing performance, but these did not constitute a worrisome pattern that suggested underlying problems. We did find that the provider did not see the CTC patients within the required intervals, but this was not a clinically significant issue. Overall, SQ gave clinically appropriate CTC care. We rated the *Specialized Medical Housing* indicator *adequate.*

Compliance Testing Results

The institution received an *adequate* compliance score of 75.0 percent in this indicator. Three tests earned scores in the *proficient* range:

- For all 10 patients sampled, nursing staff timely completed an initial health assessment the same day they admitted the patients to the CTC (MIT 13.001).
- Providers evaluated nine out of the 10 patients sampled within 24 hours of admission to the CTC (90.0 percent). For one patient, the history and physical was not completed timely (MIT 13.002).
- When inspectors observed the working order of sampled call buttons in CTC patient rooms, they 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).

One test scored in the *inadequate* range:

- When we tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required three-day intervals, we found that providers completed timely SOAPE notes for only one of 10 patients sampled (10.0 percent). For nine patients, the provider progress notes were written one to five days late (MIT 13.003).

14 — *SPECIALTY SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(82.4%)
Overall Rating:
Adequate

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

Case Review Results

We reviewed 176 events related to the *Specialty Services* indicator, which included 127 specialty consultations and procedures and 27 nursing encounters. We identified 37 deficiencies in this category, of which seven were significant. The case review rating for this indicator was *adequate*.

Access to Specialty Services

The institution generally provided specialty services within adequate time frames for routine and urgent services. Of the 127 consultations and procedures we reviewed, we found only five specialty access deficiencies. These deficiencies occurred in cases 14, 21, 22, 26, and 29. Usually, the providers caught the mistakes and reordered the services. Overall, these resulted in only mild lapses in specialty care. The following example represents one exception to this otherwise good performance:

- In case 26, the provider ordered an urgent eye surgery at the request of a specialist. The institution did not schedule the surgery until a provider caught the mistake and reordered the surgery.

Provider Performance

Providers at SQ did well with specialty performance. They made referrals to the correct specialists with the appropriate priorities. In general, the providers reviewed the specialty reports thoroughly, even if they failed to sign those reports. The anticoagulation pharmacist was diligent in tracking the patients on warfarin.

Health Information Management

The institution occasionally had difficulty retrieving specialty reports. We found that in three cases (2, 10, and 24), the institution was unable to retrieve the specialty reports:

- In case 2, the institution failed to retrieve speech therapy reports on two separate occasions.
- In case 24, the institution failed to retrieve a vascular surgery specialty report.

The institution sometimes did not properly forward specialty reports to providers. Providers could not properly review or sign the reports. We found this problem in cases 17, 20, 23, 24, and 26:

- In case 23, the institution failed to send the orthopedic surgeon report to the provider. The surgeon was concerned about a chronic bone infection and recommended continuing antibiotics. The provider did not restart the antibiotic. Fortunately, no harm resulted from the error.
- In case 24, providers did not conduct timely review of and did not sign vascular surgery and orthopedic surgery consultation reports.

In one case, the institution did not appropriately send the specialist health information needed for the specialist to make a critical medical decision:

- In case 26, the institution failed to send the recent cyclosporine levels to the nephrologist. This error forced the specialist to request repeat laboratory tests and to request a call from the provider, which resulted in delayed care.

Nursing Performance

We reviewed 11 cases in which patients returned from offsite or telemedicine specialty providers. Overall, nurses performed sufficiently with their specialty responsibilities; they usually completed their assessments and scheduled appropriate provider follow-up. Nonetheless, we found room for improvement in specialty nursing performance, as demonstrated by the following examples:

- In cases 24 and 77, nurses failed to assess the patients upon the patients' return from specialty appointments and did not review the specialty reports.
- In case 26, the nurse failed to inform the provider of the specialist recommendation to decrease the dose of the critical cyclosporine medication.

When a patient returns from an offsite specialist without a specialty report, the nurse is required to contact the specialist's office to determine if the specialist made any recommendations for the patient and to retrieve the specialty report. We identified a pattern in which nurses failed to

review the specialist's findings and recommendations or to contact the specialist's office regarding missing findings and recommendations. These errors occurred in cases 2, 9, 23, 24, and 26.

- In case 2, the patient had weekly speech therapy for several months. When the patient returned from these appointments, nurses did not document if the specialty report arrived with the patient. Additionally, the specialty nurse did not ensure that the institution received the reports. SQ did not receive two of those reports.

- In case 26, on seven different occasions, the nurse failed to contact the specialist's office to determine the specialist's findings and recommendation when the patient returned to the institution without any specialty reports.

Clinician Onsite Inspection

Triage and treatment area (TTA) nurses assessed patients upon their return from offsite specialty services. The institution utilized onsite optometry, audiology, podiatry, nephrology, orthopedics, and physical therapy specialty services. SQ incorporated telemedicine for onsite specialty services and a telemedicine nurse assisted the telemedicine provider. The telemedicine nurse also assisted in the procedure clinic once a week when the provider performed minor procedures.

Case Review Conclusion

Providers made appropriate specialty referrals when their patients needed them, and SQ provided timely access to specialty services. Upon patients' return from offsite specialty visits, SQ nurses did not always follow up on specialist findings and recommendations. The institution had some difficulties with retrieving reports, and the providers did not consistently review and sign the reports timely. Nonetheless, SQ provided good specialty care in most of the cases we reviewed. The deficiencies we identified were uncommon, and the institution should use them for quality improvement purposes. We rated the *Specialty Services* indicator *adequate.*

Compliance Testing Results

The institution received an *adequate* compliance score of 82.4 percent in this indicator, with the following three tests scoring in the *proficient* range:

- The institution provided all 15 sampled patients' high-priority specialty services appointments within 14 calendar days of the provider's order (MIT 14.001).

- Providers timely received and reviewed specialists' report for 13 of 15 sampled patients (86.7 percent). For one patient, the institution received the specialist's report 10 days late. For the remaining patient, the institution received the report one day late, and the provider reviewed the report 13 days late (MIT 14.002).

- SQ provided routine specialty service appointments to 13 of 15 patients tested within the required time frame (86.7 percent). One patient received his specialty service four days late, and the other patient's specialty service had not been provided by the date of the OIG inspection, at least 186 days late (MIT 14.003).

One test received a score in the *adequate* range:

- Providers timely received and reviewed specialists' reports following routine specialty service appointments for 11 of the 14 patients sampled (78.6 percent). For two patients, the institution received the routine specialists' reports one and four days late. For one patient, the provider reviewed the report 13 days late (MIT 14.004).

One test earned an *inadequate* score:

- When one institution approves and schedules a patient for specialty services and the patient transfers to another institution, CCHCS policy requires the receiving institution to reschedule and provide the appointment timely. Only 12 of the 20 patients sampled who transferred to SQ with an approved specialty service received their appointment within the required time frame (60.0 percent). For three patients, the appointments were one to 26 days late. One patient received his appointment 155 days late. For the remaining four patients, there were no evidence the appointments ever occurred (MIT 14.005).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(67.2%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution received an *inadequate* compliance score of 67.2 percent in this indicator, with several tests demonstrating *inadequate* performance:

- The institution had not taken adequate steps to ensure the accuracy of its Dashboard data. The QMC meetings did not discuss methodologies used in training staff responsible for collecting Dashboard data. As a result, SQ received a score of zero on this test (MIT 15.004).

- All 12 sampled incident packages for emergency medical responses did not comply with CCHCS policy. Five incident packages had incomplete Emergency Medical Response Review Committee (EMRRC) checklists. Among the remaining seven packages, the committee minutes did not document discussion of the three required questions. As a result, SQ received a score of zero on this test (MIT 15.005).

- The institution did not meet the emergency response drill requirements for the most recent quarter for all of its three watches, resulting in a score of zero. The drill packages had one or more of the following deficiencies: the drill package did not contain or completely document the required elements such as a synopsis of the event, time frame of all elements, and recommendations on areas needing improvement or additional training; the emergency drill packages did not contain a Cardiopulmonary Resuscitation Record (CDCR Form 7462) and

Triage Treatment Services Flow Sheet (CDCR Form 7464) as required by CCHCS policy (MIT 15.101).

- Ten patient deaths occurred at SQ during the OIG's testing period. Medical staff reviewed and timely submitted the Initial Inmate Death Report (CDCR Form 7477A or 7477B) to CCHCS' Death Review Unit for five patient deaths, resulting in a score of 50.0 percent. For three patient deaths, the notification to the CCHCS' Death Review Unit was one day late. The institution did not use the correct form to report one death. For another patient death, the institution did not provide any evidence that the completed form was reported to the Death Review Unit at CCHCS headquarters (MIT 15.103).

- Only one of 13 SQ providers had a proper clinical performance appraisal completed by his or her supervisor (7.7 percent). For 12 provider performance evaluation packets, one or more of the following deficiencies occurred: the supervising physician did not discuss the UHR Clinical Appraisal (UCA) reviews with the provider; the appraisal packets did not include the required Primary Care Provider (PCP) 360 Degree Evaluation; the supervising physician did not complete an annual individual development plan for a provider (it was overdue by 369 days); and the supervisor did not complete a provider's first and second probation report (they were overdue by 151 and 29 days, respectively) (MIT 15.106).

Two tests earned *adequate* scores:

- We reviewed data (not validated by the OIG) received from the institution to determine whether SQ timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12-month period. SQ timely processed nine of the 12 months' appeals (75.0 percent) (MIT 15.001).

- During the last 12 months, SQ's local governing body (LGB) met at least quarterly and exercised responsibility for the quality management of patient care in three of the four quarters (75.0 percent). The LGB failed to document one meeting date; therefore, we were unable to determine if LGB meeting minutes were approved timely during the fourth quarter (MIT 15.006).

Several tests earned scores in the *proficient* range:

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

- Based on a sample of 10 second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- All 10 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 and nurses were current with their emergency response certifications (MIT 15.108).

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

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

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports. CCHCS' Death Review Committee (DRC) did not timely complete its death review summary for any of the six SQ deaths that occurred during the OIG's inspection period. The DRC is generally required to complete a death review summary within either 30 or 60 days of death (depending on whether the death was expected or unexpected) and then notify the institution's chief executive officer (CEO) of the review results within seven calendar days, so that any needed corrective action may be promptly pursued. For two expected (level 2) patient deaths, the committee completed its summary 94 and 100 days late (124 and 130 days after death) and there was no evidence that the institution's CEO was notified of the results. For one unexpected (level 1) patient death, the DRC completed the death review summary 55 days late (115 days after death) and there was no evidence found that the institution's CEO was notified of the results. Lastly, for three other unexpected (level 1) patient deaths that occurred on August 30, 2017, September 24, 2017, and November 1, 2017, the death reviews had not been completed as of early April 2018 (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 following:

- The CNE should implement a comprehensive quality improvement program to improve the institution's delivery of reception center services because of the problems we found with nursing performance and provider appointments during this inspection.

- The CNE and pharmacist in charge should implement quality improvement measures to ensure proper medication continuity for patients returning from offsite hospitals, arriving from county jails, and receiving chronic care medications. We found marked room for improvement in these areas during this inspection.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For San Quentin State Prison, nine HEDIS measures were selected and are listed in the following *SQ 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. SQ performed very well with its management of diabetes.

When compared statewide, SQ outperformed Medi-Cal in all five diabetic measures, and outperformed Kaiser in four of the five diabetic measures. The institution scored lower in blood pressure than Kaiser (North and South regions).

When compared nationally, SQ outperformed Medicaid, commercial plans, and Medicare in all five diabetic measures. SQ outperformed the United States Department of Veterans Affairs (VA) in two of the four applicable measures, with the institution scoring lower in HbA1c testing and diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, and Medicare. With respect to administering influenza vaccinations to younger and older adults, SQ outperformed all reporting health plans. With regard to administering pneumococcal vaccines to older adults, SQ scored higher than Medicare and lower than the VA.

Cancer Screening

With respect to colorectal cancer screening, SQ outperformed all reporting health plans.

Summary

SQ performed very well overall in comparison to other health care plans with respect to population-based metrics. The institution may improve scores in influenza vaccination by reducing the number of refusals through patient education regarding the benefits of this preventive service.

SQ Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	SQ Cycle 5 Results[1]	HEDIS Medi-Cal 2017[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So.CA) 2016[3]	HEDIS Medicaid 2017[4]	HEDIS Com-mercial 2017[4]	HEDIS Medicare 2017[4]	VA Average 2016[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**97%**	87%	94%	94%	87%	91%	94%	99%
Poor HbA1c Control (>9.0%)[6, 7]	**12%**	38%	20%	23%	43%	33%	26%	18%
HbA1c Control (<8.0%)[6]	**76%**	52%	70%	63%	47%	56%	63%	-
Blood Pressure Control (<140/90)	**77%**	63%	83%	83%	60%	62%	64%	76%
Eye Exams	**87%**	57%	68%	81%	55%	54%	70%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**63%**	-	56%	57%	39%	48%	-	52%
Influenza Shots - Adults (65+)	**74%**	-	-	-	-	-	71%	72%
Immunizations: Pneumococcal	**92%**	-	-	-	-	-	74%	93%
Cancer Screening								
Colorectal Cancer Screening	**91%**	-	79%	82%	-	62%	67%	82%

1. Unless otherwise stated, data was collected in January 2018 by reviewing medical records from a sample of SQ's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services Medi-Cal Managed Care External Quality Review Technical Report (July 1, 2016 – June 30, 2017).

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

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2017 State of Health Care Quality Report, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

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

6. For this indicator, the entire applicable SQ 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

San Quentin State Prison Range of Summary Scores: 35.0% - 83.3%	
Indicator	**Compliance Score (Yes %)**
1–***Access to Care***	67.6%
2–***Diagnostic Services***	75.9%
3–***Emergency Services***	Not Applicable
4–***Health Information Management (Medical Records)***	83.3%
5–***Health Care Environment***	50.9%
6–***Inter- and Intra-System Transfers***	64.3%
7–***Pharmacy and Medication Management***	35.0%
8–***Prenatal and Post-Delivery Services***	Not Applicable
9–***Preventive Services***	66.6%
10–***Quality of Nursing Performance***	Not Applicable
11–***Quality of Provider Performance***	Not Applicable
12–***Reception Center Arrivals***	77.0%
13–***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	75.0%
14–***Specialty Services***	82.4%
15–***Administrative Operations***	67.2%

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?	16	9	25	64.0%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	11	14	25	44.0%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	32	0	32	100.0%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	22	10	32	68.8%	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	4	9	55.6%	23
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?	Not Applicable				
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	80.0%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	18	11	29	62.1%	1
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	4	2	6	66.7%	0
Overall percentage:					**67.6%**	

Reference Number	2–*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.0%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	6	4	10	60.0%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	8	2	10	80.0%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	8	2	10	80.0%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.0%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	5	5	10	50.0%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.0%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	7	2	9	77.8%	1
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	5	4	9	55.6%	1
Overall percentage:					**75.9%**	

3 – *Emergency Services*

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

Reference Number	4–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated health care documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	5	0	5	100.0%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	16	4	20	80.0%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	18	2	20	90.0%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	16	8	24	66.7%	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	80.0%	0
Overall percentage:					**83.3%**	

Reference Number	5–*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned, and sanitary?	10	2	12	83.3%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	5	7	12	41.7%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	4	12	66.7%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	3	9	12	25.0%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	12	0	12	100.0%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.0%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	6	6	12	50.0%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	7	5	12	58.3%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	11	1	12	91.7%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	4	8	12	33.3%	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?	1	9	10	10.0%	2
Overall percentage:					**50.9%**	

Reference Number	6–*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	25	0	25	100.0%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	20	0	20	100.0%	5
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?	10	5	15	66.7%	10
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	11	9	20	55.0%	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?	0	3	3	0.0%	1
Overall percentage:					**64.3%**	

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?	4	19	23	17.4%	2
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	18	7	25	72.0%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	14	10	24	58.3%	1
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?	2	5	7	28.6%	13
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	21	4	25	84.0%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	1	9	10	10.0%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	1	10	11	9.1%	1
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	7	5	12	58.3%	0
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	2	8	10	20.0%	2
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	3	5	8	37.5%	4
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	7	1	8	87.5%	4
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	1	7	8	12.5%	4
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	0	1	1	0.0%	0

Reference Number	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.0%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.0%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	0	1	1	0.0%	0
7.111	Does the institution follow key medication error reporting protocols?	0	25	25	0.0%	0
Overall percentage:					**35.0%**	

8 – *Prenatal and Post-Delivery Services*

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

Reference Number	9–*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	14	11	25	56.0%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	16	9	25	64.0%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	9	21	30	30.0%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.0%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	24	1	25	96.0%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	8	7	15	53.3%	10
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**66.6%**	

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–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
12.001	For patients received from a county jail: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	18	2	20	90.0%	0
12.002	For 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?	9	0	9	100.0%	11
12.003	For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame?	6	1	7	85.7%	13
12.004	For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days?	11	9	20	55.0%	0
12.005	For patients received from a county jail: Were all required intake tests completed within specified timelines?	19	1	20	95.0%	0
12.006	For patients received from a county jail: Did the primary care provider review and communicate the intake test results to the patient within specified timelines?	15	5	20	75.0%	0
12.007	For patients received from a county jail: Was a tuberculin test both administered and read timely?	20	0	20	100.0%	0
12.008	For patients received from a county jail: Was a Coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely?	3	17	20	15.0%	0
Overall percentage:					**77.0%**	

Reference Number	13–*Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.0%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	9	1	10	90.0%	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?	1	9	10	10.0%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	1	0	1	100.0%	0
Overall percentage:					**75.0%**	

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%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	13	2	15	86.7%	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?	13	2	15	86.7%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	11	3	14	78.6%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	12	8	20	60.0%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	Not Applicable				
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	Not Applicable				
Overall percentage:					**82.4%**	

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?	9	3	12	75.0%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.0%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.0%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.0%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	3	1	4	75.0%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.0%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100.0%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	5	5	10	50.0%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	Not Applicable				
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.0%	0
15.106	Are structured clinical performance appraisals completed timely?	1	12	13	7.7%	0
15.107	Do all providers maintain a current medical license?	14	0	14	100.0%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.0%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.0%	1

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.0%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100.0%	0
Overall percentage:					**67.2%**	

APPENDIX B — CLINICAL DATA

Table B-1: SQ Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	32
Reception Center Transfers	4
Specialty Services	4
	76

Table B-2: SQ Chronic Care Diagnoses

Diagnosis	Total
Anemia	7
Anticoagulation	3
Arthritis/Degenerative Joint Disease	10
Asthma	12
COPD	12
Cancer	9
Cardiovascular Disease	10
Chronic Kidney Disease	10
Chronic Pain	14
Cirrhosis/End Stage Liver Disease	5
Coccidioidomycosis	2
DVT/PE	2
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	25
Gastroesophageal Reflux Disease	14
Gastrointestinal Bleed	1
HIV	3
Hepatitis C	23
Hyperlipidemia	23
Hypertension	45
Mental Health	5
Migraine Headaches	2
Seizure Disorder	4
Sleep Apnea	8
Thyroid Disease	1
	253

Table B-3: SQ Event – Program

Diagnosis	Total
Diagnostic Services	160
Emergency Care	69
Hospitalization	33
Intra-System Transfers In	4
Intra-System Transfers Out	4
Not Specified	1
Outpatient Care	403
Reception Center Care	18
Specialized Medical Housing	108
Specialty Services	177
	977

Table B-4: SQ Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	4
RN Reviews Detailed	15
RN Reviews Focused	51
Total Reviews	95
Total Unique Cases	76
Overlapping Reviews (MD & RN)	19

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

San Quentin State Prison (SQ)

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 (4 per clinic) (32)	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 (5)	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	(0)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(8)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (12)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (4)	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 (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (15)	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 Evaluation, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth Month • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *(N/A at this institution)*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *(N/A at this institution)*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *(N/A at this institution)*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC (20)	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–003	CTC (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (0)	InterQual	• Review date (3–9 months) • **Randomize**
	(0)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (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 (6 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (13)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (14)	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 (6)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

February 6, 2019

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

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for San Quentin (SQ) conducted from January to October 2018. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3704.

Sincerely,

LARA SAICH
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
Stephen Tseng, M.D., Chief of Medical Inspections, OIG
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