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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

November 2022

# Cycle 6 Medical Inspection Report

## *Pleasant Valley State Prison*

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*Cover: Rod of Asclepius courtesy of Thomas Shafee*

# Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated persons[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT) available on the OIG's website.[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall assessment of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[5] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

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[1] In this report, we use the terms *patient* and *patients* to refer to *incarcerated persons.*

[2] The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care the department provides to its population.

[3] In addition to our own compliance testing and case reviews, the OIG continues to offer selected Healthcare Effectiveness Data and Information Set (HEIDIS) measures for comparison purposes.

[4] The department regularly updates its policies. The OIG updates its policy-compliance testing to reflect the department's updates and changes.

[5] If we learn a patient needs immediate care, we notify the institution's chief executive officer.

The OIG has adjusted Cycle 6 reporting in two ways. First, commencing with this reporting period, we interpret compliance and case review results together, providing a more holistic assessment of the care; and second, we consider whether institutional medical processes lead to identifying and correcting provider or system errors. The review assesses the institution's medical care on both system and provider levels.

As we did during Cycle 6, our office is continuing to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of our Cycle 6 inspection, Pleasant Valley State Prison (PVSP) was delegated back to the department by the receiver.

We completed our sixth inspection of PVSP, and this report presents our assessment of the health care provided at that institution during the inspection period between May 2021 and October 2021.[6] Data we obtained for PVSP and the on-site inspections referenced activity that occurred during the COVID-19 pandemic.[7]

Pleasant Valley State Prison (PVSP) is located in Coalinga, in Fresno County. The institution houses general population, minimum- to maximum-custody patients. PVSP operates six medical clinics where staff members handle nonurgent requests for medical services. PVSP also conducts screenings in its receiving and release (R&R) clinical area; treats patients needing urgent or emergency care in its triage and treatment area (TTA); and treats those requiring inpatient health services in its correctional treatment center (CTC). The institution primarily provides medical care for patients designated as low to medium medical risk; however, it does have a very small population of patients classified as high medical risk.

California Correctional Health Care Services (CCHCS) has designated PVSP a *basic* health care institution, an institution located in a rural area away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. PVSP's geographical location is in the western San Joaquin Valley, and the institution is one of two California prisons designated as a restricted area for patients who are at high risk for contracting coccidioidomycosis (commonly known as *valley fever*).

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews included death reviews that occurred between June 2020 and December 2020, and RN sick call reviews that occurred between June 2021 and November 2021.

[7] As of July 25, 2022, the department reported on its public tracker that 73% of its incarcerated population at PVSP was fully vaccinated while 67% of PVSP staff was fully vaccinated: www.cdcr.ca.gov/covid19/population-status-tracking.

# Summary


The OIG completed the Cycle 6 inspection of PVSP in April 2022. Our inspectors monitored the institution's delivery of medical care that occurred between May 2021 and October 2021.

The OIG rated the overall quality of health care at PVSP as ***adequate***. We list the individual indicators and ratings applicable for this institution in Table 1 below.

**Table 1. PVSP Summary Table**

| Health Care Indicators | Cycle 6 Case Review Rating | Cycle 6 Compliance Rating | Cycle 6 Overall Rating | Change Since Cycle 5* |
|---|---|---|---|---|
| *Access to Care* | *Proficient* | *Proficient* | *Proficient* | ↑ |
| *Diagnostic Services* | *Adequate* | *Inadequate* | *Inadequate* | ↓ |
| *Emergency Services* | *Adequate* | *N/A* | *Adequate* | ↑ |
| *Health Information Management* | *Adequate* | *Inadequate* | *Adequate* | = |
| *Health Care Environment* | *N/A* | *Inadequate* | *Inadequate* | = |
| *Transfers* | *Adequate* | *Inadequate* | *Adequate* | ↑ |
| *Medication Management* | *Adequate* | *Inadequate* | *Inadequate* | = |
| *Prenatal and Postpartum Care* | *N/A* | *N/A* | *N/A* | *N/A* |
| *Preventive Services* | *N/A* | *Adequate* | *Adequate* | ↓ |
| *Nursing Performance* | *Adequate* | *N/A* | *Adequate* | ↑ |
| *Provider Performance* | *Adequate* | *N/A* | *Adequate* | ↑ |
| *Reception Center* | *N/A* | *N/A* | *N/A* | *N/A* |
| *Specialized Medical Housing* | *N/A* | *N/A* | *N/A* | *N/A* |
| *Specialty Services* | *Adequate* | *Adequate* | *Adequate* | = |
| *Administrative Operations*† | *N/A* | *Adequate* | *Adequate* | = |

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 5 and Cycle 6. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† Administrative Operations is a secondary indicator and is not considered when rating the institution's overall medical quality.

Source: The Office of the Inspector General medical inspection results.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 372 patient records and 1,044 data points and used the data to answer 87 policy questions. In addition, we observed PVSP processes during an on-site inspection in January 2022. Table 2 below lists PVSP average scores from Cycles 4, 5, and 6.

### Table 2. PVSP Prison Policy Compliance Scores

*Scoring Ranges*

100%–85.0% | 84.9%–75.0% | 74.9%–0

| Medical Inspection Tool (MIT) | Policy Compliance Category | Cycle 4 Average Score | Cycle 5 Average Score | Cycle 6 Average Score |
|---|---|---|---|---|
| 1 | Access to Care | 93.3% | 87.4% | 92.1% |
| 2 | Diagnostic Services | 91.1% | 56.9% | 51.7% |
| 4 | Health Information Management | 75.4% | 85.3% | 67.7% |
| 5 | Health Care Environment | 98.0% | 53.9% | 54.3% |
| 6 | Transfers | 75.8% | 83.8% | 64.2% |
| 7 | Medication Management | 92.5% | 63.1% | 64.4% |
| 8 | Prenatal and Postpartum Care | N/A | N/A | N/A |
| 9 | Preventive Services | 81.9% | 88.2% | 78.3% |
| 12 | Reception Center | N/A | N/A | N/A |
| 13 | Specialized Medical Housing | 90.0% | 92.5% | N/A |
| 14 | Specialty Services | 92.4% | 80.6% | 76.9% |
| 15 | Administrative Operations | 79.5%* | 81.3% | 75.0% |

* In Cycle 4, there were two secondary (administrative) indicators, and this score reflects the average of those two scores. In Cycle 5 and moving forward, the two indicators were merged into one, with only one score as the result.

Source: The Office of the Inspector General medical inspection results.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 45 cases, which contained 709 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in April 2022 to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 16 ***adequate*** and four ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 12 health care indicators.[8] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes which may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the PVSP Summary Table.

In December 2021, the Health Care Services Master Registry showed that PVSP had a total population of 2,651. A breakdown of the medical risk level of the PVSP population as determined by the department is set forth in Table 3 below.[9]

**Table 3. PVSP Master Registry Data as of December 2021**

| Medical Risk Level | Number of Patients | Percentage |
|---|---|---|
| High 1 | 0 | 0 |
| High 2 | 26 | 1.0% |
| Medium | 779 | 29.4% |
| Low | 1,846 | 69.6% |
| **Total** | **2,651** | **100.0%** |

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 12-20-21.

[8] The indicators for **Reception Center**, **Prenatal Care**, and **Specialized Medical Housing** did not apply to PVSP.

[9] For a definition of *medical risk*, see CCHCS HCDOM 1.2.14, Appendix 1.9.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, PVSP had no vacant executive leadership positions, one vacant primary care provider position, 2.7 position vacancies among nursing supervisors, and 15 vacant nursing staff positions.

**Table 4. PVSP Health Care Staffing Resources as of November 2021**

| Positions | Executive Leadership* | Primary Care Providers | Nursing Supervisors | Nursing Staff† | Total |
|---|---|---|---|---|---|
| Authorized Positions | 5.0 | 6.0 | 10.7 | 88.6 | 110.3 |
| Filled by Civil Service | 5.0 | 5.0 | 8.0 | 73.6 | 91.6 |
| Vacant | 0.0 | 1.0 | 2.7 | 15.0 | 18.7 |
| Percentage Filled by Civil Service | 100.0% | 83.3% | 74.8 | 83.1% | 83.0% |
| Filled by Telemedicine | 0.0 | 1.0 | 0.0 | 0.0 | 1.0 |
| Percentage Filled by Telemedicine | 0.0% | 16.7% | 0.0% | 0.0% | 0.9% |
| Filled by Registry | 0.0 | 0.0 | 0.0 | 11.0 | 0.0 |
| Percentage Filled by Registry | 0.0% | 0.0% | 0.0% | 5.1% | 0.0% |
| Total Filled Positions | 5.0 | 6.0 | 8.0 | 73.6 | 92.6 |
| **Total Percentage Filled** | **100.0%** | **100.0%** | **74.8%** | **83.1%** | **84.0%** |
| Appointments in Last 12 Months | 0.0 | 0.0 | 0.0 | 17.0 | 17.0 |
| Redirected Staff | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Staff on Extended Leave‡ | 0.0 | 0.0 | 2.0 | 9.0 | 11.0 |
| **Adjusted Total: Filled Positions** | **5.0** | **6.0** | **6.0** | **64.6** | **81.6** |
| **Adjusted Total: Percentage Filled** | **100.0%** | **100.0%** | **56.1%** | **72.9%** | **74.0%** |

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes the classifications of Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

Notes: The OIG does not independently validate staffing data received from the department. Positions are based on fractional time-base equivalents.

Source: Cycle 6 medical inspection preinspection questionnaire staffing matrix received November 15, 2021, from California Correctional Health Care Services.

# Medical Inspection Results

## Deficiencies Identified During Case Review

*Deficiencies* are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency.

An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10]

The OIG did not find any adverse events at PVSP during the Cycle 6 inspection.

## Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed nine of the 12 indicators applicable to PVSP. Of these nine indicators, OIG clinicians rated one ***proficient*** and eight ***adequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 16 were ***adequate***, and four were ***inadequate***. In the 709 events reviewed, there were 165 deficiencies, 15 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at PVSP:

- Staff performed well with access to care, ensuring provider and nursing appointments occurred within required time frames.
- Providers and nurses delivered appropriate and timely emergency medical care in the triage and treatment area (TTA).
- Nursing staff performed well with assessment and interventions for patients who transferred in, transferred out, and who were hospitalized.
- Radiology staff performed well in providing radiology services timely, including on-site mobile special imaging services (CT and MRI) and general imaging services.[11]

[10] For a further discussion of an adverse event, see Table A-1.

[11] A CT is a computerized tomography imaging scan. An MRI is a magnetic resonance imaging scan.

Our clinicians found the following weaknesses at PVSP:

- Providers did not send or make available patient test result notification letters containing all required elements.
- Nursing staff did not perform well in the outpatient assessment for patients and nursing documentation.

## Compliance Testing Results

Our compliance inspectors assessed nine of the 12 indicators applicable to PVSP. Of these nine indicators, our compliance inspectors rated one ***proficient***, three ***adequate***, and five ***inadequate***. We tested policy compliance in the **Health Care Environment**, **Preventative Services**, and **Administrative Operations** indicators as they do not have a case review component.

PVSP demonstrated a high rate of policy compliance in the following areas:

- The institution excelled in providing timely appointments for chronic care patients, patients returning from hospital admission, and patients returning from specialty services. Moreover, patients were referred within required time frames to their providers upon arrival at the institution.
- Nursing staff at PVSP reviewed health care services request forms and conducted face-to-face encounters within required time frames. In addition, PVSP housing units contained adequate supplies of health care request forms.

PVSP demonstrated a low rate of policy compliance in the following areas:

- The institution did not consistently provide routine and STAT laboratory services within the specified time frames.
- Providers did not often communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.
- Medical clinics at PVSP did not meet requirements for essential core medical equipment and supplies. Almost all clinics that we tested were missing properly calibrated medical equipment and medical supplies required to provide standard medical care.
- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.
- Nursing staff did not regularly inspect emergency response bags and treatment carts.

## Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report,* the OIG obtained Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

## HEDIS Results

We considered PVSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. PVSP's results compared favorably with those found in State health plans for diabetic care measures. We list the nine HEDIS measures in Table 5.

### Comprehensive Diabetes Care

Statewide comparison data is only available for one of the five diabetic measures. When compared with statewide Medi-Cal programs (California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal), PVSP performed better in poor HbA1c control than all managed care plans. We include HbA1c screening, HbA1c control, blood pressure control, and eye examination data for informational purposes.

### Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. PVSP had a 28 percent influenza immunization rate for adults 18 to 64 years old. Immunization data for adults 65 years and older and the pneumococcal vaccine rate were not available at this sample interval.[12]

### Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. PVSP had an 85 percent colorectal cancer screening rate.

[12] The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result. The sample for older adults did not include a full sample.

**Table 5. PVSP Results Compared With State HEDIS Scores**

| HEDIS Measure | PVSP Cycle 6 Results* | California Medi-Cal 2018† | California Kaiser NorCal Medi-Cal 2018 † | California Kaiser SoCal Medi-Cal 2018 † |
|---|---|---|---|---|
| HbA1c Screening | 100% | – | – | – |
| Poor HbA1c Control (> 9.0%) ‡, § | **12%** | 42% | 34% | 23% |
| HbA1c Control (< 8.0%) ‡ | 82% | – | – | – |
| Blood Pressure Control (< 140/90) ‡ | 88% | – | – | – |
| Eye Examinations | 78% | – | – | – |
| Influenza – Adults (18–64) | 28% | – | – | – |
| Influenza – Adults (65+) ‖ | N/A | – | – | – |
| Pneumococcal – Adults (65+) ‖ | N/A | – | – | – |
| Colorectal Cancer Screening | 85% | – | – | – |

*Notes and Sources*

* Unless otherwise stated, data were collected in January 2022 by reviewing medical records from a sample of PVSP's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled, *Medi-Cal Managed Care External Quality Review Technical Report* (published April 2022).

‡ For this indicator, the entire applicable PVSP population was tested.

§ For this measure only, a lower score is better.

‖ For these measures, fewer than 10 samples could be provided within the testing time frame and thus were not considered.

Source: Institution information provided by the California Department of Corrections and Rehabilitation. Health Care plan data were obtained from the CCHCS Master Registry.

## Recommendations

As a result of our assessment of PVSP's performance, we offer the following recommendations to the department:

### Diagnostic Services

- Medical leadership should ensure that laboratory services for both routine and STAT (immediate) tests are completed timely and that providers are notified with STAT results timely.
- The department should consider developing strategies to ensure that providers create patient letters at the time of review and endorsement and that patient letters contain all elements required per CCHCS policy.

### Health Information Management

- Medical leadership should ensure that providers are communicating all results with patients timely and that patient notification letters contain all required elements.
- The department should consider developing strategies to ensure that specialty notes are scanned into the medical records timely.
- Medical leadership should ascertain causative factors related to the mislabeling of scanned documents and implement remedial measures as appropriate.

### Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure the EMRBs and treatment carts are regularly inventoried and sealed.

### Transfers

- Nursing leadership should educate nursing staff on the requirements for documenting an initial health screening.

### Medication Management

- The institution should consider developing and implementing measures to ensure that staff timely make available and administer the medications to patients and that staff document in the MAR summaries as described in CCHCS policy and procedures.

### Provider Performance

- The department should consider strategies to improve the number of providers.

### Specialty Services

- Specialty services' medical leadership should ensure that providers are endorsing specialists' reports timely.

## Access to Care

Overall Rating ***Proficient***

Case Review Rating ***Proficient***

Compliance Score ***Proficient*** **(92.1%)**

In this indicator, OIG inspectors evaluated the institution's performance in providing patients with timely clinical appointments. Our inspectors reviewed the scheduling and appointment timeliness for newly arrived patients, sick call, and nurse follow-up appointments. We examined referrals to primary care providers, provider follow-ups, and specialists. Furthermore, we evaluated the follow-up appointments for patients who received specialty care or returned from an off-site hospitalization.

## *Results Overview*

PVSP provided excellent access to care. OIG clinicians found that most appointments and referrals were completed timely including appointments with clinic providers, nurses, and follow-up care after the specialists' appointments. In addition, the overall compliance testing rating was superior with a score of 92.1 percent. After reviewing all aspects, the OIG rated this indicator ***proficient***.

### Case Review and Compliance Testing Results

OIG clinicians reviewed 162 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified seven deficiencies relating to **Access to Care**, none of which were significant.[13]

#### Access to Clinic Providers

PVSP performed well with referrals to providers and requests for provider follow-up. Failure to ensure provider appointment availability can cause lapses in care. Compliance testing found that 84.0 percent of chronic care follow-up appointments occurred on time (MIT 1.001), 63.6 percent of nurse-to-provider follow-up appointments occurred timely as requested (MIT 1.005), and 100 percent of sick call follow-up appointments occurred timely (MIT 1.006). OIG clinicians reviewed 53 clinic provider encounters and did not identify any deficiencies.

#### Access to Specialized Medical Housing Providers

During the review period, the correctional treatment center (CTC) was not operational due to construction.

#### Access to Clinic Nurses

PVSP performed well with access for nursing sick calls and provider-to-nurse referrals. Compliance testing found that all nursing sick call requests were reviewed on the same day they were received (MIT 1.003,

[13] Deficiencies occurred twice in case 17, and once in cases 15, 18, 19, 20 and 36.

100%), and face-to-face visits that were completed within one day after the sick call requests were almost always reviewed timely (MIT 1.004, 93.3%). Our clinicians assessed 65 sick call triage nursing encounters and identified one deficiency, which was not significant. An example is below:

- In case 36, nursing staff assessed the patient during a face-to-face encounter for a sick call request and ordered a follow-up appointment for 14 days. However, the nursing follow-up visit occurred one day late.

### Access to Specialty Services

PVSP had a mixed performance in its referrals to specialty services. Compliance testing found that 60.0 percent of the initial high-priority specialty appointments occurred within the required time frame (MIT 14.001), 80.0 percent of the initial medium-priority specialty appointments (MIT 14.004), and 100 percent of the initial routine-priority specialty appointments (MIT 14.007) occurring in a timely manner. The institution also had variable results with follow-up specialty appointments. Compliance testing found that 75.0 percent of patients received their subsequent high-priority specialty appointments (MIT 14.003), 100 percent of the subsequent medium-priority specialist appointments (MIT 14.006), and 66.7 percent of the subsequent routine specialty service appointments (MIT 14.009) within the required time frames. Our clinicians assessed 40 specialty service events and identified five deficiencies.[14] The following is an example of an identified deficiency:

- In case 17, the provider requested a follow-up surgery specialty appointment in three weeks. However, the specialist appointment occurred nine days late.

### Follow-Up After Specialty Service

PVSP performed well in ensuring patients saw their providers within required time frames after specialty appointments. Compliance testing revealed that 88.1 percent of provider appointments after specialty services occurred timely (MIT 1.008). The OIG clinicians evaluated 40 specialty service events and did not identify any missed or delayed appointments with their providers.

### Follow-up After Hospitalization

PVSP performed well in ensuring that patients saw their providers within required time frames after hospitalization. Compliance testing found that 100 percent of provider appointments after hospitalization occurred within the required time frame (MIT 1.007). The OIG clinicians

[14] Deficiencies occurred once each in cases 15, 17, 18, 19, and 20.

reviewed 11 hospital returns and did not identify any missed or delayed appointments.

### Follow-up After Urgent or Emergent Care (TTA)

PVSP performed well for patient with provider follow-up appointments after urgent or emergent care at the triage and treatment area (TTA). Our clinicians assessed 12 TTA events and did not identify any delayed or missed provider follow-up appointments.

### Follow-up After Transferring Into the Institution

PVSP performed well in providing appointments for newly arrived patients within required time frames (MIT 1.002, 100%). Our clinicians evaluated nine transfer-in events and did not identify any deficiencies with delayed appointments.

### Clinician On-Site Inspection

PVSP had clinics in four Facilities (A Yard, B Yard, C Yard, and D Yard), including short-term restricted housing (STRH), and a correctional treatment center (CTC) which housed the TTA, a specialty clinic, and a R&R area. At the time of our on-site inspection, the CTC medical beds were unavailable due to ongoing construction at this center.

The OIG clinicians attended morning huddles and a provider meeting, which were all well attended. The office technician reported scheduling, on average, 12 appointments per day for each provider. Staff reported there was no backlog of appointments at the time of our inspection. Staff reported midlevel providers, two nurse practitioners (NP) and one physician assistant (PA), who worked additional hours to meet the demands of primary care access to reduce backlogs when needed. The chief physician and surgeon (CP&S) reported the institution had one provider vacancy, and that despite the additional pay differential being offered, noted recruiting candidates was challenging due to the prison's location.

## Compliance Testing Results

### Table 6. Access to Care

| Compliance Questions | Scored Answer Yes | No | N/A | Yes % |
|---|---|---|---|---|
| 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? (1.001) * | 21 | 4 | 0 | 84.0% |
| For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) * | 25 | 0 | 0 | 100% |
| Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) * | 30 | 0 | 0 | 100% |
| Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) * | 28 | 2 | 0 | 93.3% |
| 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? (1.005) * | 7 | 4 | 19 | 63.6% |
| 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? (1.006) * | 5 | 0 | 25 | 100% |
| Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) * | 7 | 0 | 2 | 100% |
| Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,† | 37 | 5 | 3 | 88.1% |
| Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101) | 6 | 0 | 0 | 100% |
| | | | Overall percentage (MIT 1): 92.1% | |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following specialty services. As a result, we tested MIT 1.008 only for high-priority specialty services or when staff ordered follow-ups. The OIG continued to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

## Table 7. Other Tests Related to Access to Care

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| 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? (12.003) * | N/A | N/A | N/A | N/A |
| For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) * | N/A | N/A | N/A | N/A |
| For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) * | N/A | N/A | N/A | N/A |
| For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,† | N/A | N/A | N/A | N/A |
| Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) * | 9 | 6 | 0 | 60.0% |
| Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) * | 6 | 2 | 7 | 75.0% |
| Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) * | 12 | 3 | 0 | 80.0% |
| Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) * | 4 | 0 | 11 | 100% |
| Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) * | 15 | 0 | 0 | 100% |
| Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) * | 4 | 2 | 9 | 66.7% |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still had state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

## *Recommendations*

The OIG offers no recommendations for this indicator.

## Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Overall Rating
***Inadequate***

Case Review Rating
***Adequate***

Compliance Score
***Inadequate* (51.7%)**

## *Results Overview*

PVSP had a mixed performance in completing diagnostic tests, and in retrieving and communicating diagnostic tests results. Its staff completed radiology testing and pathology studies within appropriate time frames. Our case reviewers found only two significant deficiencies. In addition, PVSP had difficulty processing routine and STAT laboratory tests in a timely manner. Staff did not always retrieve pathology reports within required time frames. After reviewing all aspects of diagnostic services, we rated this indicator ***inadequate***.

### Case Review and Compliance Testing Results

The OIG clinicians reviewed 217 diagnostic events and found 90 deficiencies, two of which were significant. Of those 90 deficiencies, we found 87 related to health information management and three related to the performance by providers and nurses in managing ordered tests.[15]

For health information management, we considered test reports that were never retrieved or reviewed as severe a problem as tests that were not performed. We discuss this further in the **Health Information Management** indicator.

#### Test Completion

PVSP performed well in completing radiology services (MIT 2.001, 100%), but not as well completing laboratory services (MIT 2.004, 70.0%) and it performed poorly in completing STAT laboratory services (MIT 2.007, zero) within required time frames. The OIG clinicians reviewed 18 radiology tests and 196 laboratory tests and did not find any deficiencies in test completion. There were no STAT laboratory tests or results examined in case reviews.

[15] Deficiencies occurred 10 times in case 1, nine times in case 13, seven times in cases 8, 16, and 18, six times in case 2, five times in cases 10, 12, and 21, four times in cases 4, 17, and 19, thrice in cases 14 and 20, twice in cases 6, 7, 9, 11, and 15, and once in case 5. The significant deficiencies occurred in cases 15 and 19. Deficiencies related to providers' and nurses' performance in managing ordered tests occurred in cases 18, 19, and 21.

### Health Information Management

Providers reviewed and endorsed the reports within specified time frames for radiology (MIT 2002, 90.0%) and the laboratory (MIT 2.005, 90.0%). However, PVPS performed poorly in nursing notification of STAT laboratory tests or results (MIT 2.008, zero), and staff did not always retrieve pathology report within required time frames (MIT 2.010, 70.0%). Providers always reviewed and endorsed pathology reports (MIT 2.011, 100%), but did not communicate the results of pathology studies to the patients within required time frames (MIT 2.012, zero).

The OIG clinicians identified 90 deficiencies, with most related to health information management in creating patient notification letters (81 of 90 deficiencies).[16] We identified six deficiencies in delays in obtaining provider endorsements of results, but none of these were significant.[17] The following are examples:

- In case 1, the provider reviewed and endorsed the urine toxicology results and created a patient notification letter. However, the letter did not indicate whether the results were within normal limits.

- In case 4, the provider endorsed the laboratory results, but did not create a patient notification letter in the patient's electronic health record.

### Clinician On-Site Inspection

The OIG clinicians met with laboratory and radiology staff. At the time of our on-site visit, the radiology service was fully staffed and provided on-site mobile CT and MRI imaging services as well as general x-ray, ultrasound, and FibroScan services.[18] Staff reported that special imaging services (CT and MRI) are scheduled with another nearby institution to meet the minimal number of cases needed for regular scheduling. Quest Diagnostics, an external laboratory vendor, provides laboratory and pathology diagnostic service for the institution. Once the specimen is collected, Quest Diagnostics interfaced laboratory and pathology results directly to the electronic health record system for health care teams to review.

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[16] Deficiencies occurred 10 times in case 1, nine times in case 13, seven times in cases 8 and 16, five times in case 18, four times in cases 4, 10, 12, 17, and 21, thrice in cases 14, 19, and 20, twice in cases 6, 7, 9, and 11, and once in cases 5 and 15.

[17] Deficiencies occurred twice in case 2 and once in cases 10, 12, 15, and 18.

[18] A CT is a computerized tomography imaging scan. An MRI is a magnetic resonance imaging scan. A FibroScan is a diagnostic imaging test that evaluates for liver scarring and fatty changes from liver disease.

## Compliance Testing Results

### Table 8. Diagnostic Services

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) * | 10 | 0 | 0 | 100% |
| Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) * | 9 | 1 | 0 | 90.0% |
| Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003) | 0 | 10 | 0 | 0 |
| Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) * | 7 | 3 | 0 | 70.0% |
| Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) * | 9 | 1 | 0 | 90.0% |
| Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006) | 0 | 10 | 0 | 0 |
| Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) * | 0 | 2 | 0 | 0 |
| Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) * | 0 | 2 | 0 | 0 |
| Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009) | 2 | 0 | 0 | 100% |
| Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) * | 7 | 3 | 0 | 70.0% |
| Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) * | 10 | 0 | 0 | 100% |
| Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012) | 0 | 10 | 0 | 0 |
| Overall percentage (MIT 2): **51.7%** | | | | |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

## *Recommendations*

- Medical leadership should ensure that laboratory services for both routine and STAT (immediate) tests are completed timely and that providers are notified with STAT results timely.

- The department should consider developing strategies to ensure that providers create patient letters at the time of review and endorsement and that patient letters contain all elements required per CCHCS policy.

## Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) performance in identifying problems with its emergency services. The OIG assessed the institution's emergency services mainly through case review.

Overall Rating
***Adequate***

Case Review Rating
***Adequate***

Compliance Score
**(N/A)**

### *Results Overview*

Compared with Cycle 5, PVSP's performance in emergency services improved as providers and nurses delivered good emergency care. The providers and nurses also provided good documentation. Overall, the OIG rated this indicator ***adequate***.

### Case Review Results

We reviewed 25 urgent/emergent events and found eight emergency care deficiencies, none of which were significant.[19]

#### Emergency Medical Response

PVSP custody and health care staff responded promptly to emergencies throughout the institution. They initiated cardiopulmonary resuscitation (CPR), activated emergency medical services (EMS), and notified TTA staff timely.

#### Provider Performance

PVSP providers made appropriate decisions for patients who arrived at the TTA for emergency treatment. On-call providers were available for consultation with the TTA staff, and most documented their phone calls with the nurses except in cases 1 and 15.

#### Nursing Performance

PVSP nurses generally provided good nursing assessments and interventions. However, the following case showed room for improvement:

[19] Deficiencies occurred thrice in case 15, twice in cases 1 and 13, and once in cases 3.

- In case 13, the patient was unable to move his body, and his pulse was elevated. The nurse did not recheck the patient's pulse until an hour after the initial check.

### Nursing Documentation

Nurses provided good documentation related to their findings, timelines, and sequences of events.

### Emergency Medical Response Review Committee

Compliance testing found EMRRC checklists could not be located in most cases (MIT 15.003, 25.0%). Our clinicians did not identify any deficiencies and discuss this further in the **Administrative Operations** indicator.

### Clinician On-Site Inspection

Staff reported that two RNs and a provider staffed the unit. The patient care area had sufficient space to provide emergency care. Nursing staff reported they had a good rapport with custody staff.

The OIG clinicians met with nursing leadership and medical providers and discussed some of our case review findings. Nursing leadership reported that education from our case review findings would be provided to nursing staff.

## *Recommendations*

The OIG offers no specific recommendations for this indicator.

## Health Information Management

In this indicator, OIG inspectors evaluated the flow of health information, a crucial link in high-quality medical care delivery. Our inspectors examined whether the institution retrieved and scanned critical health information (progress notes, diagnostic reports, specialist reports, and hospital discharge reports) into the medical record in a timely manner. Our inspectors also tested whether clinicians adequately reviewed and endorsed those reports. In addition, our inspectors checked whether staff labeled and organized documents in the medical record correctly.

Overall Rating
***Adequate***

Case Review Rating
***Adequate***

Compliance Score
***Inadequate***
**(67.7%)**

### *Results Overview*

As in Cycle 5, PVSP performed satisfactorily in this indicator. Medical staff's performance in retrieving and scanning hospital discharge records and diagnostic results was within appropriate time frames. However, the institution did not ensure that providers communicate test results with patient notification letters containing all required elements. In addition, institutional staff did not always retrieve and review specialty reports timely. Taking all factors into consideration, the OIG rated this indicator ***adequate.***

### Case Review and Compliance Testing Results

OIG clinicians reviewed 709 events and found 95 deficiencies related to health information management, one of which was significant.[20] The majority of deficiencies (81 out of 95 deficiencies) in health information management pertained to patient notification letters that were either not created or incomplete.[21]

#### Hospital Discharge Reports

PVSP staff performed well in retrieving and scanning hospital discharge documents into patients' electronic health records within required time frames (MIT 4.003, 87.5%). Most of the hospital discharge reports contained physician discharge summaries, and providers reviewed these reports timely (MIT 4.005, 77.8%). The OIG clinicians reviewed 11 off-site emergency department and hospital visits, and did not identify any deficiencies.

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[20] Deficiencies occurred 10 times in cases 1 and 13; eight times in cases 12, 16, and 18; six times in cases 2 and 8; five times in cases 10 and 21; four times in cases 4 and 17; thrice in cases 14, 15, 19, and 20; twice in cases 6, 7, 9, and 11; and once in case 5. A significant deficiency occurred in case 12.

[21] Deficiencies in which letters were not created occurred twice in cases 4 and 7, and once in cases 1, 5, 8, 9, 11, 12, 13, 19, and 21. Deficiencies in which letters were incomplete occurred nine times in case 9, eight times in case 13, seven times in case 16, five times in cases 8 and 18, four times in cases 2, 10, 12, and 17, thrice in cases 14, 20, and 21, twice in cases 4, 6, and 19, once in cases 9, 11, and 15.

### Specialty Reports

Overall, PVSP staff did not perform well in retrieving and reviewing specialty reports. Compliance testing showed that 73.3 percent of specialty reports were scanned into the electronic health record system within required time frames (MIT 4.002). PVSP staff generally received and reviewed high-priority specialty service consultant reports within the required time frame (MIT 14.002, 84.6%). However, they did not always receive and review routine and medium-priority specialty service consultant reports timely (MIT 14.005, 73.3%; MIT 14.008, 53.3%). These findings are discussed further in the **Specialty Services** indicator. Our clinicians reviewed 34 specialty events and identified seven deficiencies, one of which was significant.[22] The following is an example:

- In case 12, the provider endorsed the surgical procedure notes that were retrieved and scanned into the electronic health record system 11 days late.

### Diagnostic Reports

PVSP staff performed well in retrieving and endorsing diagnostic reports timely. Compliance testing showed providers often endorsed radiology and laboratory reports within required time frames (MIT 2.002, 90.0%, and MIT 2.005, 90.0%). Providers reviewed and endorsed pathology reports within required time frame (MIT 2.011, 100%), but performed poorly communicating results of the pathology study to patients within required time frames (MIT 2.012, zero). Staff did not always receive the final pathology reports within the required time frames (MIT 2.010, 70.0%). Our clinicians identified 86 deficiencies, none of which were significant.[23] The majority of deficiencies (81 out of 86 deficiencies) were related to patient notification letters. The following is an example:

- In case 21, the provider endorsed laboratory test results and created a patient notification letter in the electronic health record system. However, the letter did not include the date of the test.

PVSP staff performed poorly in collecting STAT laboratory tests and receiving those results within the required time frame (MIT 2.007, zero), and in notifying the provider within the required time frame (MIT 2.008, zero). Even so, providers endorsed STAT laboratory results within the required time frames (MIT 2.009, 100%). The OIG clinicians did not have any STAT laboratory tests in their case review samples. Related deficiencies are discussed further in the **Diagnostic Services** indicator.

[22] Deficiencies occurred thrice in case 12, twice in case 18, and once in cases 13 and 21. A significant deficiency occurred in case 12.

[23] Deficiencies occurred 10 times in case 1, nine times in case 13, seven times in case 16, six times in cases 28, 8, and 18, five times in cases 10 and 12, four times in cases 4, 17, and 21, thrice in cases 14, 19, and 20, twice in cases 6, 7, 9, 11, and 15, and once in case 5.

### Urgent and Emergent Records

OIG clinicians reviewed 25 emergency care events and found that, in general, PVSP nurses recorded these events well. Providers also recorded their emergency care sufficiently most of the time. OIG clinicians did not find any deficiencies in documentation prepared by nursing staff or providers. The **Emergency Services** indicator provides additional details.

### Scanning Performance

PVSP staff performed poorly with the scanning process. Compliance testing showed that staff did not properly scan, label, or name medical files (MIT 4.004, zero). OIG clinicians found four deficiencies with mislabeled documents, none of which were significant.[24] The following is an example:

- In case 18, a telemedicine cardiothoracic surgeon evaluated the patient. However, this specialist report was mislabeled as a cardiology consultation in the patient's electronic health record.

### Clinician On-Site Inspection

Our clinicians discussed health information management processes with PVSP office technicians, the health information management supervisor, ancillary staff, and providers. The supervisor reported that the area is short-staffed and is in the process of hiring an office assistant.

We discussed with medical leadership the required elements in the patient notification letter when providers communicate diagnostic results with patients to ensure future performance would be improved.

[24] Deficiencies occurred twice in case 18, and once in cases 15 and 16.

## Compliance Testing Results

### Table 9. Health Information Management

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001) | 20 | 0 | 10 | 100% |
| Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) * | 22 | 8 | 15 | 73.3% |
| Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) * | 7 | 1 | 1 | 87.5% |
| During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) * | 0 | 24 | 0 | 0 |
| For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) * | 7 | 2 | 0 | 77.8% |
| | | | | Overall percentage (MIT 4): **67.7%** |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

## Table 10. Other Tests Related to Health Information Management

| | Scored Answer | | | |
|---|---|---|---|---|
| **Compliance Questions** | **Yes** | **No** | **N/A** | **Yes %** |
| Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) * | 9 | 1 | 0 | 90.0% |
| Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) * | 9 | 1 | 0 | 90.0% |
| Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) * | 0 | 2 | 0 | 0 |
| Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) * | 7 | 3 | 0 | 70.0% |
| Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) * | 10 | 0 | 0 | 100% |
| Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012) | 0 | 10 | 0 | 0 |
| Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) * | 11 | 2 | 2 | 84.6% |
| Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) * | 11 | 4 | 0 | 73.3% |
| Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) * | 8 | 7 | 0 | 53.3% |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

## *Recommendations*

- Medical leadership should ensure that providers are communicating all results with patients timely and that patient notification letters contain all required elements.
- The institution should consider developing strategies to ensure that specialty notes are scanned into the medical records timely.
- Medical leadership should ascertain causative factors related to the mislabeling of scanned documents and implement remedial measures as appropriate.

## Health Care Environment

In this indicator, OIG compliance inspectors tested clinics' waiting areas, infection control, sanitation procedures, medical supplies, equipment management, and examination rooms. Inspectors also tested clinics' performance in maintaining auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score, using the same scoring thresholds used in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Overall Rating
***Inadequate***

Case Review Rating
**(N/A)**

Compliance Score
***Inadequate***
**(54.3%)**

### *Results Overview*

Multiple aspects of PVSP's health care environment showed a need for improvement: multiple clinics contained expired medical supplies, contained noncalibrated or nonfunctional equipment; emergency medical response bags (EMRB) had expired or were lacking medical supplies; EMRB logs were missing staff verification, or EMRB inventories were not performed; and staff did not regularly sanitize their hands before or after examining patients. These factors resulted in an ***inadequate*** rating for this indicator.

### Compliance Testing Results

#### Outdoor Waiting Areas

We examined outdoor patient waiting areas. Both health care and custody staff reported existing waiting areas had sufficient seating capacity (see Photo 1). Staff reported the outdoor waiting area was only utilized when the indoor waiting area was at capacity. In addition, staff reported that during inclement weather, they only call patients close to their appointment time.

Photo 1. Outdoor waiting area (photographed on January 11, 2022).

### Indoor Waiting Areas

We inspected indoor waiting areas. Patients had enough seating capacity while waiting for their appointments (see Photo 2). Depending on the population, patients were either placed in a holding area or held in an individual module to await their medical appointments (see Photo 3).

Photo 2. Specialty indoor waiting area (photographed on January 13, 2022).


Photo 3. Specialty individual waiting module (photographed on January 13, 2022).

These holding areas had temperature controls, running water, and toilets, but not all clinic waiting areas had hand sanitation items such as antiseptic soaps. Moreover, Clinic A's waiting area had insufficient space to sit four patients, as reported by custody staff, which we confirmed (see Photo 4).

Photo 4. A clinic indoor waiting area had an insufficient seating area for four patients (photographed on January 11, 2022).

### Clinic Environment

Eight of nine clinic environments were sufficiently conducive for medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 88.9%). In one clinic, we observed nursing staff provided services to patients in the vital signs check station while the clinic door was open with another patient sitting by the door, which affected auditory privacy.

Of the nine clinics we observed, seven contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 77.8%). In one clinic, the examination room chair had a torn vinyl cover. The remaining clinic's examination table placement prevented patients from fully reclining (see Photo 5).


Photo 5. Examination table placement prevented patient from fully reclining (photographed on January 13, 2022).

### Clinic Supplies

Two of the nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, 22.2%). We found one or more of the following deficiencies in seven clinics: expired medical supplies (see Photos 6 and 7), unidentified or inaccurately labeled medical supplies, compromised original medical supply packaging, staff members' personal items and food stored in the supply storage cabinet (see Photo 8), and cleaning materials stored with medical supplies.


Photo 6. Expired EMRB stored supply dated July 2020 (photographed on January 11, 2022).

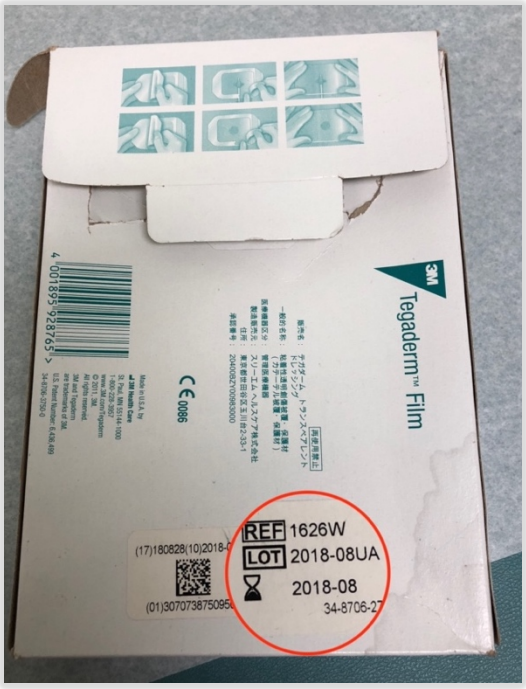



Photo 7. Expired medical supply dated August 2018 (photographed January 11, 2022).


Photo 8. Staff members' personal items and food stored in the supply storage cabinet (photographed on January 12, 2022).

Only one of the nine clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 11.1%). The remaining eight clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included disposable paper for examination tables, a glucometer and strips, an ophthalmoscope and tips, and a nebulizer. The staff had not properly calibrated a nebulizer, an oto-ophthalmoscope, a pulse oximeter, and an automated external defibrillator (AED). We found that the Snellen reading chart did not have a corresponding distance line marked on either the floor or the wall. We also found nonfunctional ophthalmoscopes. In addition, staff did not complete the following: glucometer quality control checks and a defibrillator performance test in accordance with the manufacturer's instructions within the last 30 days.

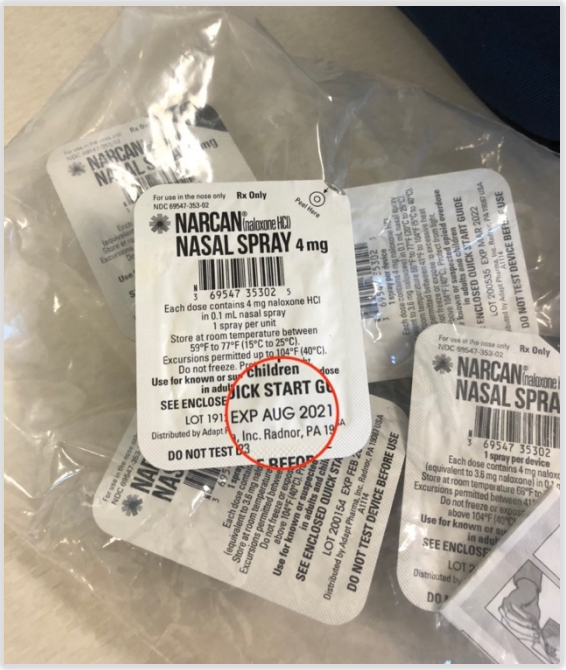



Photo 9. Expired EMRB stored supply dated August 2021(photographed on January 11, 2022).

We examined EMRBs to determine whether they contained all essential items. We checked if staff inspected the bags daily and inventoried them monthly. None of the seven EMRBs passed our test (MIT 5.111, zero). We found one or more of the following deficiencies present with all the EMRBs: staff failed to ensure the EMRB's compartments were sealed and intact, staff either had not inventoried the EMRBs when seal tags were replaced or had not inventoried the EMRBs in the previous 30 days. There were expired medical supplies (see Photos 9 and 10) and compromised sterile medical supply packaging, there was a missing nasopharyngeal airway, and staff failed or inaccurately logged EMRB daily glucometer quality control results. The treatment cart in the TTA did not meet the minimum inventory level and there was no documentation that reasonable substitutions were made.

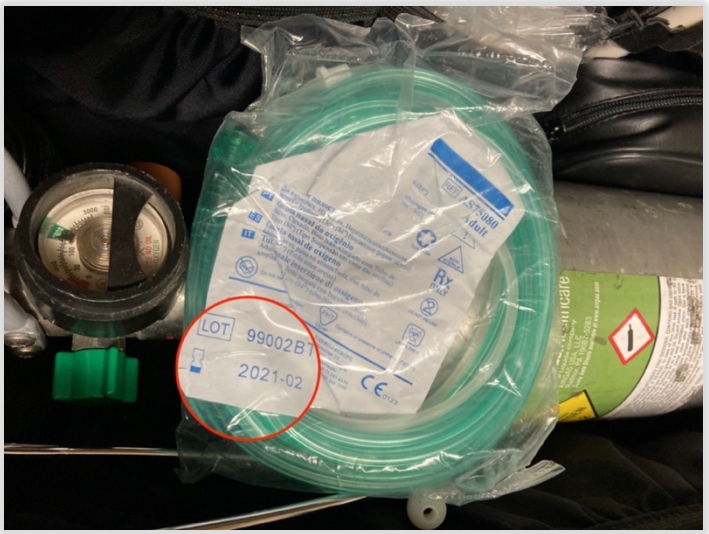



Photo 10. Expired EMRB stored supply dated February 2021 (photographed on January 12, 2022).

### Medical Supply Management

All the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, 100%). According to the chief executive officer (CEO), PVSP did not have any concerns about the medical supplies process. Health care and medical warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system.

### Infection Control and Sanitation

Staff appropriately, cleaned, sanitized, and disinfected five of nine clinics (MIT 5.101, 55.6%). In four clinics, we found one or more of the following deficiencies: cleaning logs were not maintained; test strips were expired, and therefore could not show whether the cleaning solution met the proper sanitation level; biohazardous waste was not emptied from the previous day; and the medication room sink cabinet had a buildup of grime.

Staff in six of nine clinics (MIT 5.102, 66.7%) properly sterilized or disinfected medical equipment. In three clinics, we found one or both of the following deficiencies: staff did not mention disinfecting the examination table as part of their daily start-up protocol or staff did not regularly log sterilized reusable medical equipment.

We found operating sinks and hand hygiene supplies in the examination rooms in seven of nine clinics (MIT 5.103, 77.8%). In one clinic, the patient restroom lacked antiseptic soap and disposable paper towels. The remaining clinic's patient restroom had a sink that was not functional.

We observed patient encounters in five clinics. In four clinics, clinicians did not wash their hands before or after examining their patients, or before applying gloves (MIT 5.104, 20.0%).

Health care staff in seven of nine clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 77.8%). In two clinics, we found the sharps containers were overfilled.

### Physical Infrastructure

PVSP's health care management and plant operations manager reported all clinical areas infrastructures were in good working order and did not hinder health care services.

At the time of our medical inspection, the institution reported the Health Care Facility Improvement Program (HCFIP) project was underway. There were renovations taking place in the CTC, the TTA, the physical

therapy room, and expansions were underway on all yard clinics. The projects had started between November 2019 and March 2020. Health care managers reported most projects were delayed due to the State Fire Marshall's pending approval. The institution estimated these projects will be completed between March 2022 and December 2022 (MIT 5.999).

## Compliance Testing Results

### Table 11. Health Care Environment

| | Scored Answer | | | |
|---|---|---|---|---|
| **Compliance Questions** | **Yes** | **No** | **N/A** | **Yes %** |
| Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101) | 5 | 4 | 0 | 55.6% |
| Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102) | 6 | 3 | 0 | 66.7% |
| Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103) | 7 | 2 | 0 | 77.8% |
| Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104) | 1 | 4 | 4 | 20.0% |
| Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105) | 7 | 2 | 0 | 77.8% |
| Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106) | 1 | 0 | 0 | 100% |
| Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107) | 2 | 7 | 0 | 22.2% |
| Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108) | 1 | 8 | 0 | 11.1% |
| Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109) | 8 | 1 | 0 | 88.9% |
| Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110) | 7 | 2 | 0 | 77.8% |
| Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111) | 0 | 7 | 2 | 0 |
| Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999) | This is a nonscored test. Please see the indicator for discussion of this test. | | | |
| | Overall percentage (MIT 5): **54.3%** | | | |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

### *Recommendations*

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure the EMRBs and treatment carts are regularly inventoried and sealed.

## Transfers

Overall Rating
***Adequate***

Case Review Rating
***Adequate***

Compliance Score
***Inadequate***
**(64.2%)**

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution, as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed whether staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the performance of staff communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed whether staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

### *Results Overview*

PVSP's performance was mixed in this indicator. During this inspection, the OIG clinicians reviewed more events and found fewer deficiencies compared with Cycle 5. PVSP performed well for patients who transferred out of the institution, and performed satisfactorily for patients who transferred into the institution and who returned from the hospital or emergency room. However, we found incomplete initial health screening forms when patients transferred into the institution. Considering both case review and compliance results, the OIG rated this indicator ***adequate***.

### Case Review and Compliance Testing Results

OIG clinicians reviewed 37 events in 19 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified four deficiencies, two of which were significant.[25]

#### Transfers In

PVSP's transfer-in process was satisfactory. Receiving nurses evaluated patients appropriately and requested provider appointments within required time frames. However, compliance testing found nurses did not complete the initial health screening forms thoroughly (MIT 6.001, 8.0%). Analysis of compliance data revealed nursing staff did not always follow

[25] Deficiencies occurred in cases 14 and 15. Significant deficiencies occurred twice in case 16.

up with additional questions when patients responded "yes" to some of the screening questions.

PVSP provided excellent access to primary care providers for patients who transferred into the institution. Both the clinicians and compliance testing found all appointments occurred within required time frames (MIT 1.002, 100%).

The OIG clinician found all newly arrived patients were medicated timely. Compliance testing found good medication continuity for newly arrived patients (MIT 6.003, 84.6%).

When patients transferred into PVSP with preapproved specialty appointments, compliance testing found appointments generally did not occur timely (MIT 14.010, 35.0%).

### Transfers Out

PVSP's transfer-out process was excellent. Our clinicians found nurses performed face-to-face evaluations, completed the interfacility transfer information, and medicated patients prior to their transfer. There were no applicable transfer-out cases for the compliance team to observe or examine during the review period.

### Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients typically experience severe illness or injury, requiring more care and placing a strain on the institution's resources. In addition, because these patients have complex medical issues, successful health information transfer is necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

PVSP's hospitalization process was satisfactory. Compliance testing found patient discharge documents were scanned within the required time frame (MIT 4.003, 87.5%) and providers reviewed the documents timely (MIT 4.005, 77.8%). Our clinicians found all discharge documents were scanned and reviewed timely. In addition, nurses performed good nursing assessments and provided good documentation.

Both compliance and clinicians testing found PVSP provided timely follow-up appointments when patients returned from the hospital and emergency rooms (MIT 1.007, 100%).

Compliance testing found PVSP did not ensure medication continuity for its patients (MIT 7.003, 57.1%). Our clinicians identified two significant deficiencies related to lapses in medication continuity. The following is an example:

- In case 16, the patient with a history of asthma returned from the hospital with a diagnosis of pneumonia. PVSP staff did not reconcile

all the patient's medications. Subsequently, the patient did not receive his rescue inhaler for two weeks. In addition, the patient did not receive his maintenance inhaler for more than a month. This placed the patient at risk for potential respiratory complications.

### Clinician On-Site Inspection

Our clinician visited the R&R area and met with its nursing staff and found the transfer nurse knowledgeable about the transfer process. We also met with nursing leadership to discuss some of our clinical findings. Leadership indicated training would be provided.

## Compliance Testing Results

### Table 12. Transfers

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) * | 2 | 23 | 0 | 8.0% |
| For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial 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? (6.002) | 25 | 0 | 0 | 100% |
| 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? (6.003) * | 11 | 2 | 12 | 84.6% |
| For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) * | 0 | 0 | 3 | N/A |
| Overall percentage (MIT 6): **64.2%** | | | | |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

### Table 13. Other Tests Related to Transfers

| Compliance Questions | Scored Answer Yes | No | N/A | Yes % |
|---|---|---|---|---|
| For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) * | 25 | 0 | 0 | 100% |
| Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) * | 7 | 0 | 2 | 100% |
| Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) * | 7 | 1 | 1 | 87.5% |
| For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) * | 7 | 2 | 0 | 77.8% |
| 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? (7.003) * | 4 | 3 | 2 | 57.1% |
| Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) * | 22 | 3 | 0 | 88.0% |
| For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) * | 3 | 0 | 0 | 100% |
| 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? (14.010) * | 7 | 13 | 0 | 35.0% |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

## *Recommendations*

- Nursing leadership should educate nursing staff on the requirements for documenting an initial health screening.

## Medication Management

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. When rating this indicator, the OIG strongly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Overall Rating
***Inadequate***

Case Review Rating
***Adequate***

Compliance Score
***Inadequate***
**(64.4%)**

### *Results Overview*

PVSP had a mixed performance in this indicator. Compared with Cycle 5, case reviewers identified fewer deficiencies as PVSP performed well for newly prescribed medications, transfer medications, and medication administration. However, compliance testing found PVSP had room for improvement in managing continuity of chronic care medications and hospital discharge medications. After careful consideration of all factors, we rated this indicator ***inadequate***.

### Case Review and Compliance Testing Results

We reviewed 110 events in 28 cases related to medications and found seven medication deficiencies, four of which were significant.[26]

#### New Medication Prescriptions

Both compliance sampling and case reviewers found newly prescribed medications were often available and administered within required time frames. PVSP scored 92.0 percent in compliance testing (MIT 7.002), while the case review did not identify any significant deficiencies.

#### Chronic Medication Continuity

Compliance testing found patients did not receive their chronic care medications timely (MIT 7.001, 13.3%). In contrast, our clinicians found most patients received their medications on time. However, we identified one significant deficiency as show below:

- In case 16, the patient had a fungal lung infection. The patient's antifungal medication had expired. Subsequently, the patient missed five doses of the medication. This placed the patient at risk for insufficient treatment.

[26] Deficiencies occurred thrice in case 16, and once in cases 9, 13, 17, and 19. Significant deficiencies occurred thrice in case 16 and once in case 19.

### Hospital Discharge Medications

Compliance testing found patients returning from off-site hospitals or emergency rooms did not receive their medications within required time frames (MIT 7.003, 57.1%). Our clinicians found one significant medication deficiency. Please refer to the **Transfers** indicator for more discussion.

### Specialized Medical Housing Medications

There were no cases during the review period due to the temporary closure of specialty medical housing.

### Transfer Medications

Compliance testing showed patients often received their medication within required time frames when they transferred into the institution (MIT 6.003, 84.6%). Patients transferring from one housing unit to another also frequently received their medications timely (MIT 7.005, 88.0%). Layover patients received their medications within required time frames (MIT 7.006, 100%). Our clinicians found all patients transferring into and out of PVSP received their medications timely.

### Medication Administration

Compliance testing found nurses regularly administered TB medications as prescribed (MIT 9.001, 84.0%). All nurses administered medications properly.

### Clinician On-site Inspection

Our clinicians interviewed medication nurses and found they were knowledgeable about the medication process. They attended clinic huddles and notified the providers of expiring medications. We also met with the pharmacy staff and nursing leadership to discuss some of our findings. Nursing leadership reported that they would provide training in regard to our findings.

### Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in seven of eight clinic and medication line locations (MIT 7.101, 87.5%). In one location, nurses could not describe the narcotic medication discrepancy reporting process.

PVSP appropriately stored and secured nonnarcotic medications in four of seven clinic and medication line locations (MIT 7.102, 57.1%). In three locations, we found one or more of the following deficiencies: staff did not maintain the security of medications when they were not in active use, the refrigerated medications did not have a designated area for

medications to be returned to the pharmacy, staff stored medications with an expired prescription date label and did not return medication to the pharmacy. There were also a disorganized medication storage cabinet and an unsecured treatment cart.

Staff kept medications protected from physical, chemical, and temperature contamination in only one of the seven clinic and medication line locations (MIT 7.103, 14.3%). In six locations, we found one or more of the following deficiencies: staff did not consistently record the room and refrigerator temperatures, staff did not store oral and topical medications separately, and staff did not separate medications from disinfectants.

Staff appropriately stored valid, unexpired medications in five of the seven applicable medication line locations (MIT 7.104, 71.4%). In two locations, nurses did not label multiple use medication as per CCHCS policy, or medication was stored beyond its expiration date.

Nurses exercised proper hand hygiene and contamination control protocols in four of seven locations (MIT 7.105, 57.1%). In three locations, some nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in three of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 42.9%). In four locations, medication nurses did not maintain unissued medication in its original labeled packaging, or medication nurses could not describe the process they followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physician's order.

Staff in one of seven medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 14.3%). In six clinics, we found one or more of the following deficiencies: medication nurses did not reliably observe patients while they swallowed direct observation therapy medications, medication nurses did not follow the CCHCS care guide when administering Suboxone medication, and nurses could not describe the medication error reporting process.

### Pharmacy Protocols

PVSP followed general security, organization, and cleanliness management protocols for nonrefrigerated and refrigerated medications stored in its pharmacy (MIT 7.108, 7.109, and 7.110, 100%).

The pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. In addition, nurses present at the time of the medication-area inspection did not correctly complete several medication-area inspection checklists (CDCR Form 7477). These errors resulted in a score of zero in this test (MIT 7.111).

We examined 12 medication error reports. The PIC timely and correctly processed all reports (MIT 7.112, 100%).

### Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors also followed up on any significant medication errors found during compliance testing. We did not score this test; we provide these results for informational purposes only. At PVSP, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in restrictive housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Six of eight applicable patients we interviewed indicated they had access to their rescue medications. The remaining two patients reported they did not have their prescribed rescue inhalers. Patients told us that the medication was either taken away and placed in their property when transferred to the restrictive housing unit or the patient threw away the medication. We promptly notified the CEO of this concern, and health care management immediately reissued replacement rescue inhalers to the patients (MIT 7.999).

## Compliance Testing Results

### Table 14. Medication Management

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| 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? (7.001) * | 2 | 13 | 10 | 13.3% |
| Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002) | 23 | 2 | 0 | 92.0% |
| 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? (7.003) * | 4 | 3 | 2 | 57.1% |
| 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? (7.004) * | N/A | N/A | N/A | N/A |
| Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) * | 22 | 3 | 0 | 88.0% |
| For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) * | 3 | 0 | 0 | 100% |
| All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101) | 7 | 1 | 2 | 87.5% |
| All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102) | 4 | 3 | 3 | 57.1% |
| All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103) | 1 | 6 | 3 | 14.3% |
| All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104) | 5 | 2 | 3 | 71.4% |
| Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105) | 4 | 3 | 3 | 57.1% |
| Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106) | 3 | 4 | 3 | 42.9% |
| Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107) | 1 | 6 | 3 | 14.3% |
| Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108) | 1 | 0 | 0 | 100% |
| Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109) | 1 | 0 | 0 | 100% |
| Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110) | 1 | 0 | 0 | 100% |
| Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111) | 0 | 1 | 0 | 0 |
| Pharmacy: Does the institution follow key medication error reporting protocols? (7.112) | 12 | 0 | 0 | 100% |
| Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998) | This is a nonscored test. Please see the indicator for discussion of this test. | | | |
| Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999) | This is a nonscored test. Please see the indicator for discussion of this test. | | | |
| | | | | Overall percentage (MIT 7): **64.4%** |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

## Table 15. Other Tests Related to Medication Management

| | Answer | | | |
|---|---|---|---|---|
| **Compliance Questions** | **Yes** | **No** | **N/A** | **Yes %** |
| 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? (6.003) * | 11 | 2 | 12 | 84.6% |
| For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) * | 0 | 0 | 3 | N/A |
| Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) * | 21 | 4 | 0 | 84.0% |
| Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) * | 0 | 25 | 0 | 0 |
| Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) * | N/A | N/A | N/A | N/A |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

## *Recommendations*

- The institution should consider developing and implementing measures to ensure that staff timely make available and administer the medications to patients and that staff document in the MAR summaries as described in CCHCS policy and procedures.

## Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as high risk for coccidioidomycosis (valley fever), we tested the institution's ability to transfer out patients quickly. The OIG rated this indicator solely according to the compliance score, using the same scoring thresholds used in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Overall Rating
***Adequate***

Case Review Rating
**(N/A)**

Compliance Score
***Adequate***
**(78.3%)**

### *Results Overview*

PVSP generally performed well in administering TB medication to patients, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, offering colorectal cancer screening for patients from ages 45 through 75, and offering required immunizations to chronic care patients. The institution also transferred out patients who were at the highest risk of coccidioidomycosis (valley fever) infection. However, PVSP did not always monitor patients taking prescribed TB medications. Overall, the OIG rated this indicator ***adequate***.

## Compliance Testing Results

### Table 16. Preventive Services

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) | 21 | 4 | 0 | 84.0% |
| Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) † | 0 | 25 | 0 | 0 |
| Annual TB screening: Was the patient screened for TB within the last year? (9.003) | 23 | 2 | 0 | 92.0% |
| Were all patients offered an influenza vaccination for the most recent influenza season? (9.004) | 25 | 0 | 0 | 100% |
| All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005) | 23 | 2 | 0 | 92.0% |
| Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006) | N/A | N/A | N/A | N/A |
| Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007) | N/A | N/A | N/A | N/A |
| Are required immunizations being offered for chronic care patients? (9.008) | 8 | 2 | 15 | 80.0% |
| Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009) | 25 | 0 | 0 | 100% |
| | | | | Overall percentage (MIT 9): **78.3%** |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the electronic health record system (EHRS) PowerForm for tuberculosis (TB)-symptom monitoring.

Source: The Office of the Inspector General medical inspection results.

## *Recommendations*

The OIG offers no specific recommendations for this indicator.

## Nursing Performance

Overall Rating
***Adequate***

Case Review Rating
***Adequate***

Compliance Score
**(N/A)**

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' performance in making timely and appropriate assessments and interventions. We also evaluated the institution's nurses' performance in many clinical settings and processes, including sick call, outpatient care, care coordination and management, emergency services, specialized medical housing, hospitalizations, transfers, specialty services, and medication management. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

When summarizing overall nursing performance, our clinicians understand that nurses perform numerous aspects of medical care. As such, specific nursing quality issues are discussed in other indicators, such as **Emergency Services, Specialty Services, and Specialized Medical Housing**.

## *Results Overview*

PVSP nurses provided good nursing care, which improved from Cycle 5. Overall, nurses performed good nursing assessments and interventions for patients in the following areas: emergency, specialty, and transfers. In addition, we identified fewer deficiencies in this cycle. However, the areas of outpatient nursing assessment and nursing documentation needed improvement. Considering all these factors, the OIG rated this indicator ***adequate.***

### Case Review Results

We reviewed 189 nursing encounters. Of the nursing encounters we reviewed, 123 were in the outpatient setting. We identified 33 nursing performance deficiencies, one of which was significant.[27]

#### Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes elements both subjective (patient interview) and objective (observation and examination). Overall, PVSP nurses provided good nursing assessments and interventions. However, nursing assessments and intervention in the outpatient setting showed room for improvement. The following are examples:

[27] Deficiencies occurred in cases 1, 3, 4, 5, 9 through 19, 21, 30, 31, 39, and 43. A significant deficiency occurred in case 4.

- In case 4, the provider ordered COVID-19 isolation rounds twice a day for 14 days, but nurses did not always perform isolation rounds as ordered.

- In case 15, the patient complained of severe left hip pain and the inability to walk. The nurse did not assess the patient's skin color or temperature of the hip area.

### Nursing Sick Call

Our clinicians reviewed 65 sick call requests. Generally, nurses triaged patient sick call requests appropriately and performed timely evaluations for patients with symptoms. However, the following nursing assessments and interventions demonstrated room for improvement:

- In case 1, the patient reported that he had a seizure. The sick call nurse noted the patient had abrasions on his chin and one eyebrow. However, the nurse did not notify the provider.

- In case 12, the patient requested to see the provider because his medication was causing his skin to bruise. The nurse mislabeled the sick call request as asymptomatic. Subsequently, the symptomatic patient did not receive an RN face-to-face appointment the next day. Fortunately, the provider evaluated the patient two days later and addressed the issue during a chronic care visit.

### Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. The outpatient nursing documentation showed room for improvement. The following are examples:

- In case 10, the nurse noted COVID-19 quarantine rounds were conducted, but did not document the results or findings.

- In case 14, the patient complained of an arm abscess. The sick call nurse notified the provider, but did not document the provider's name. In addition, the nurse did not document the pain medication on the medication administration record.

- In case 43, the patient complained of ear pain. The sick call nurse did not document the appearance of the tympanic membrane.[28]

[28] The tympanic membrane is also known as the eardrum, a thin tissue layer that separates the middle ear from the external ear.

### Emergency Services

We reviewed 11 urgent or emergent cases and found nurses responded promptly to emergent events. In addition, nurses performed good nursing assessments, interventions, and documentation, which we detail further in the **Emergency Services** indicator.

### Hospital Returns

We reviewed 11 cases related to hospital returns and found most nurses performed good nursing assessments, which we detail further in the **Transfers** indicator.

### Transfers

We reviewed 10 cases that involved the transfer-in and transfer-out process. Nurses performed well. Receiving nurses evaluated patients appropriately and requested provider appointments within required time frames. Transfer-out nurses screened patients appropriately and documented pertinent information. Please refer to the **Transfers** indicator for further details.

### Specialized Medical Housing

There were no cases during the review period due to the temporary closure of specialty medical housing.

### Specialty Services

We reviewed seven cases in which patients returned from off-site specialty appointments. Nurses performed excellent assessments, reviewed the specialists' findings and recommendations, and communicated those results to the provider.

### Medication Management

We reviewed 28 cases and found that all nurses administered patients' medications as prescribed. The **Medication Management** indicator provides further information.

### Clinician On-Site Inspection

Our clinicians spoke with nurses in the TTA, R&R, specialty services, outpatient clinic, and medication areas. We attended organized clinic huddles. Sick call nurses reported they saw an average of eight patients a day. Nursing staff reported nursing morale was generally good.

Nursing leadership informed us that they performed sick call audits. We met with nursing leadership to discuss some of our case review findings. The chief nursing executive invited the nursing instructors to the meeting, who reported that they planned to provide education and training for quality improvement.

## *Recommendations*

The OIG offers no specific recommendations for this indicator.

## Provider Performance

Overall Rating
***Adequate***

Case Review Rating
**Adequate**

Compliance Score
**(N/A)**

In this indicator, OIG case review clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. Our clinicians assessed the institution's providers' performance in evaluating, diagnosing, and managing their patients properly. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. We assessed provider care through case review only and performed no compliance testing for this indicator.

## *Results Overview*

PVSP providers delivered satisfactory patient care. Providers generally made appropriate assessments, diagnosed medical conditions correctly, and managed chronic medical conditions effectively. They referred patients appropriately to specialists and for a higher level of care when needed. However, we found room for improvement in the completion of medical assessments and related documentation. Overall, the OIG rated this indicator ***adequate***.

### Case Review Results

In our inspection, we reviewed 97 medical provider encounters and identified 23 deficiencies related to provider performance, nine of which were significant.[29] In addition, OIG clinicians examined the care quality in 20 comprehensive case reviews. Of these 20 cases, 16 were rated ***adequate*** and four ***inadequate***.[30]

#### Assessment and Decision-Making

Providers generally made appropriate assessments and sound medical decisions for their patients. Most of the time, providers diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to appropriate specialists when needed. However, our clinicians identified six deficiencies related to poor medical assessment and decision-making, four of which were significant.[31] The following are examples:

- In case 1, the provider evaluated the patient with a history of seizure disorder who presented with a seizure after a head injury. The

[29] Deficiencies occurred four times in case 16, thrice in case 18, twice in cases 1, 2, 9, 12, 17, and 19, and once in cases 8, 13, 14, and 15. Significant deficiencies occurred twice in cases 17, 18, and 19, and once in cases 2, 9, and 16.

[30] ***Inadequate*** cases were cases 2, 16, 18, and 19.

[31] Deficiencies occurred twice in cases 17 and 19, and once in cases 1 and 9. Significant deficiencies occurred twice in cases 17 and 19.

provider did not consider head imaging to evaluate for the intracranial injury.

- In case 17, the provider reviewed laboratory results that showed elevated liver enzyme levels which were more than five times the upper limit of normal, indicating significant liver toxicity while taking tuberculosis (TB) medications. Although the provider sent a patient notification letter stating that a follow-up appointment would be scheduled, the appointment did not occur, and the provider did not intervene. Fortunately, the liver enzyme levels had returned to the normal range by the following regular monthly TB medication monitoring period.

### Review of Records

For patients returning from hospitalizations, providers generally performed well in reviewing medical records and addressing hospitalists' recommendations. Providers also generally performed well in reviewing MARs and reconciling patients' medications for medication continuity. However, our clinicians identified four deficiencies, two of which were significant.[32] The following are examples:

- In case 2, the provider assessed the patient after a hospitalization for chest pain and a heart attack. The provider did not thoroughly review the hospital discharge summary to initiate the recommended outpatient cardiology evaluation.

- In case 16, the provider assessed the patient after a hospitalization for bilateral pneumonia from a coccidioidomycosis fungal infection. The provider did not thoroughly review the discharge records and recommendations requesting specialists' referrals for an infectious disease specialist and a lung specialist. Furthermore, the provider did not reconcile all hospital discharge medications.

### Emergency Care

Providers generally made good triage decisions when patients arrive at TTA for emergency treatment. In addition, the providers were always available for consultation with the TTA nursing staff. We discuss this further in the **Emergency Services** indicator.

### Chronic Care

Providers appropriately managed their patients' chronic health conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. However, we identified two deficiencies in

[32] Deficiencies occurred twice in case 16 and once in cases 2 and 8. Significant deficiencies occurred in cases 2 and 16.

managing chronic conditions, neither of which was significant.[33] The following is an example:

- In case 12, the provider assessed the patient during a chronic care visit for hypertension, hyperlipidemia, prediabetes, gastroesophageal reflux disease (GERD), and skin conditions. However, the provider did not document any vital signs during this visit.

### Specialty Services

Providers normally referred patients to specialists when needed, reviewed specialty consultation reports timely, and followed recommendations adequately most of the time. However, we identified four deficiencies, two of which were significant.[34] The following is an example:

- In case 18, the provider assessed the patient for follow-up of pulmonary fungal infection and discontinued the antifungal medication, fluconazole, without documenting the rationale for not following the infectious disease specialist's recommendation.

We discuss providers' specialty performance further in the **Specialty Services** indicator.

### Documentation Quality

Providers generally documented outpatient and TTA encounters on the same day of the encounter. Although most of the time, providers correctly documented the encounter, they did not always document on-call progress notes when required. Our clinicians identified seven deficiencies related to documenting on-call progress notes, one of which was significant.[35] The following are examples:

- In case 9, nursing staff assessed the patient for lung pain and pressure, and co-consulted with the physician on-call (POC) who ordered a chest
  X-ray and a blood test for fungus, and prescribed a medication (ibuprofen). However, the provider did not document an on-call progress note and prescribed a nonsteroidal anti-inflammatory drug (NSAID), ibuprofen, to the patient who was already taking another NSAID (Naprosyn).

- In case 15, the patient presented to the TTA with abdominal pain and the TTA RN co-consulted with the provider who prescribed pain medication and recommended transferring the patient for a higher-

[33] Deficiencies occurred in cases 12 and 13.

[34] Deficiencies occurred thrice in case 18, and once in case 1. Significant deficiencies occurred twice in case 18.

[35] Deficiencies occurred twice in case 16 and once in cases 1, 2, 9, 14, and 15. A significant deficiency occurred in case 9.

level of care. However, the provider did not document a progress note in the patient's electronic health record.

### Provider Continuity

PVSP staff assigned providers to specified clinics to ensure patients' continuity of care. OIG clinicians did not identify any deficiencies related to provider continuity.

### Clinician On-Site Inspection

We observed morning huddles and attended a provider team meeting. The meetings were well-attended and pertinent information was distributed and shared. At the time of our visit, the medical providers were short staffed with one on-site provider, one telemedicine provider, and three midlevel providers (two nurse practitioners and one physician assistant). The chief physician and surgeon (CP&S) participated in physician-on-call rotations and also covered the clinics when needed. The leadership expressed its challenges in filling the provider-vacancy position mainly due to the location of the institution.

## *Recommendations*

- The department should consider strategies to improve the number of providers.

## Specialty Services

Overall Rating
***Adequate***

Case Review Rating
***Adequate***

Compliance Score
***Adequate* (76.9%)**

In this indicator, OIG inspectors evaluated the quality of specialty services. The OIG clinicians focused on the institution's performance in providing needed specialty care. Our clinicians also examined specialty appointment scheduling, providers' specialty referrals, and medical staff's retrieval, review, and implementation of any specialty recommendations.

### *Results Overview*

As in Cycle 5, PVSP provided satisfactory specialty services for its patients. Staff generally completed specialty appointments within required time frames. Providers made appropriate referrals and offered follow-up care after specialty services. However, the institution did not ensure all high-priority specialty appointments occurred timely and did not always ensure specialty consulting notes were scanned into electronic health record in the appropriate time frame. Considering performances with compliance and case reviews, the OIG rated this indicator ***adequate***.

### Case Review and Compliance Testing Results

OIG clinicians reviewed 53 events related to **Specialty Services**, which included 34 specialty consultations and procedures, five on-site specialty services, and 17 nursing encounters. There were 14 deficiencies in this category, three of which were significant.[36]

#### Access to Specialty Services

Compliance testing showed that patients did not always receive specialty services timely according to their high-priority referrals (MIT 14.001, 60.0%) and transfer continuity of specialty services (MIT 14.010, 35.0%). Specialty services were often provided timely with medium-priority referrals (MIT 14.004, 80.0%) and routine-priority referrals (MIT 14.007, 100%). OIG clinicians identified six deficiencies related to specialty appointments.[37] The following is an example:

- In case 20, the provider requested a urology referral with high priority (within 14 days), but the appointment was delayed for 20 days.

[36] Deficiencies occurred four times in case 12, thrice in case 18, twice in case 19, and once in cases 13, 16, 17, 20, and 21. Significant deficiencies occurred in cases 12, 16, and 19.

[37] Deficiencies occurred in cases 10, 12, 13, 21, 36, and 38.

### Provider Performance

Providers mostly referred patients appropriately and followed the specialists' recommendations. Compliance testing showed that providers generally followed patients after specialty service visits within required time frames (MIT 1.008, 88.1%). However, our clinicians identified one deficiency showing that the provider did not implement the specialist's recommendation as described below:

- In case 19, the provider reviewed and endorsed the specialist's report that recommended aspirin for 30 days after surgery to prevent blood clot formation. However, no treatment with aspirin was provided to the patient after hospital discharge.

### Nursing Performance

The specialty nurses reviewed specialty service requests and appropriately scheduled patients for specialty appointments. TTA nurses properly assessed patients after returning from specialty appointments, reviewed specialists' recommendations, and communicated them to the providers. OIG clinicians reviewed 17 nursing encounters related to specialty services and identified one deficiency.[38] This is discussed further in the **Nursing Performance** indicator.

### Health Information Management

Providers often reviewed high-priority specialty reports within the required time frame (MIT 14.002, 84.6%). However, providers did not always review medium-priority and routine reports timely (MIT 14.005, 73.3% and MIT 14.008, 53.3 %, respectively). The staff did not always scan consulting reports into patients' electronic health records timely (MIT 4.002, 73.3%). OIG clinicians identified four deficiencies related to delay in retrieving and scanning specialist consultant reports within required time frames.[39] Two other deficiencies were mislabeled specialty reports.[40] The following are examples:

- In case 21, the patient received a portable sleep study, and the interpretive polysomnogram report was scanned into the electronic health record three days late.

- In case 18, the patient saw a telemedicine cardiothoracic surgeon. The consulting report was scanned into the electronic health record and mislabeled as an infectious disease specialty consultation.

[38] A deficiency occurred in case 12.

[39] Deficiencies occurred twice in case 12, and once in cases 13 and 21.

[40] Deficiencies occurred twice in case 18.

### Clinician On-Site Inspection

We discussed specialty referral management with PVSP nursing leadership, providers, specialty nurses, and the utilization management nurse. They reported that nursing staff review specialty requests, contact specialists for available appointments, and schedule the appointments. They reported utilizing telemedicine for specialty services when needed. PVSP typically offers on-site specialty services in the CTC facility including optometry, podiatry, orthotics, audiology evaluation, and physical therapy. Leadership informed us that the medical providers have an X-waiver for medication assisted treatment (MAT) program on-site.[41] The CTC was not operational at the time of our inspection due to temporary closure.

[41] An X-waiver refers to the ability to prescribe medication treatment such as buprenorphine for the treatment of opioid substance use disorder.

## Compliance Testing Results

### Table 17. Specialty Services

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) * | 9 | 6 | 0 | 60.0% |
| Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) * | 11 | 2 | 2 | 84.6% |
| Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) * | 6 | 2 | 7 | 75.0% |
| Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) * | 12 | 3 | 0 | 80.0% |
| Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) * | 11 | 4 | 0 | 73.3% |
| Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) * | 4 | 0 | 11 | 100% |
| Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) * | 15 | 0 | 0 | 100% |
| Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) * | 8 | 7 | 0 | 53.3% |
| Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) * | 4 | 2 | 9 | 66.7% |
| 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? (14.010) * | 7 | 13 | 0 | 35.0% |
| Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011) | 20 | 0 | 0 | 100% |
| Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012) | 17 | 1 | 2 | 94.4% |
| | | | Overall percentage (MIT 14): **76.9%** | |

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

## Table 18. Other Tests Related to Specialty Services

| Compliance Questions | Yes | No | N/A | Yes % |
|---|---|---|---|---|
| Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, † | 37 | 5 | 3 | 88.1% |
| Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) * | 22 | 8 | 15 | 73.3% |

* The OIG clinicians considered these compliance tests along with their own case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following most specialty services. As a result, we test 1.008 only for high-priority specialty services or when the staff orders PCP or PC RN follow-ups. The OIG continues to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

## *Recommendations*

- Specialty services' medical leadership should ensure that providers are endorsing specialists' reports timely.

## Administrative Operations

Overall Rating
***Adequate***

Case Review Rating
**(N/A)**

Compliance Score
***Adequate***
**(75.0%)**

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined whether the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors examined whether the institution provided training and job performance reviews for its employees. We checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely according to the compliance score, using the same scoring thresholds used in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Because none of the tests in this indicator affected clinical patient care directly (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

### *Results Overview*

PVSP's performance was mixed in this indicator as the institution scored well in some applicable tests, but faltered in others. The institution performed well in managing nursing annual competency training and in maintaining licenses and certifications. However, the Emergency Medical Response Review Committee (EMRRC) did not review the cases timely and did not always complete the required checklists. The institution conducted medical emergency response drills with incomplete documentation. Physician managers did not always complete annual performance appraisals in a timely manner. These findings are set forth in the table on the next page. Overall, we rated this indicator ***adequate***.

#### Nonscored Results

At PVSP, the OIG did not have any applicable adverse sentinel events requiring root cause analysis during our inspection period (MIT 15.001).

The institution did not report any unexpected (Level 1) or expected (Level 2) deaths during the OIG testing period (MIT 15.998).

## Compliance Testing Results

### Table 19. Administrative Operations

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) * | N/A | N/A | N/A | N/A |
| Did the institution's Quality Management Committee (QMC) meet monthly? (15.002) | 6 | 0 | 0 | 100% |
| For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003) | 3 | 9 | 0 | 25.0% |
| For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004) | N/A | N/A | N/A | N/A |
| Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101) | 0 | 3 | 0 | 0 |
| Did the responses to medical grievances address all of the inmates' appealed issues? (15.102) | 10 | 0 | 0 | 100% |
| Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103) | N/A | N/A | N/A | N/A |
| Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104) | 10 | 0 | 0 | 100% |
| Did physician managers complete provider clinical performance appraisals timely? (15.105) | 0 | 5 | 1 | 0 |
| Did the providers maintain valid state medical licenses? (15.106) | 7 | 0 | 0 | 100% |
| Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107) | 2 | 0 | 1 | 100% |
| Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108) | 6 | 0 | 1 | 100% |
| Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109) | 1 | 0 | 0 | 100% |
| Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110) | 1 | 0 | 0 | 100% |
| Did the CCHCS Death Review Committee process death review reports timely? (15.998) | This is a nonscored test. Please refer to the discussion in this indicator. | | | |
| What was the institution's health care staffing at the time of the OIG medical inspection? (15.999) | This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information. | | | |
| | Overall percentage (MIT 15): **75.0%** | | | |

* Effective March 2021, this test was for informational purposes only.

Source: The Office of the Inspector General medical inspection results.

## *Recommendations*

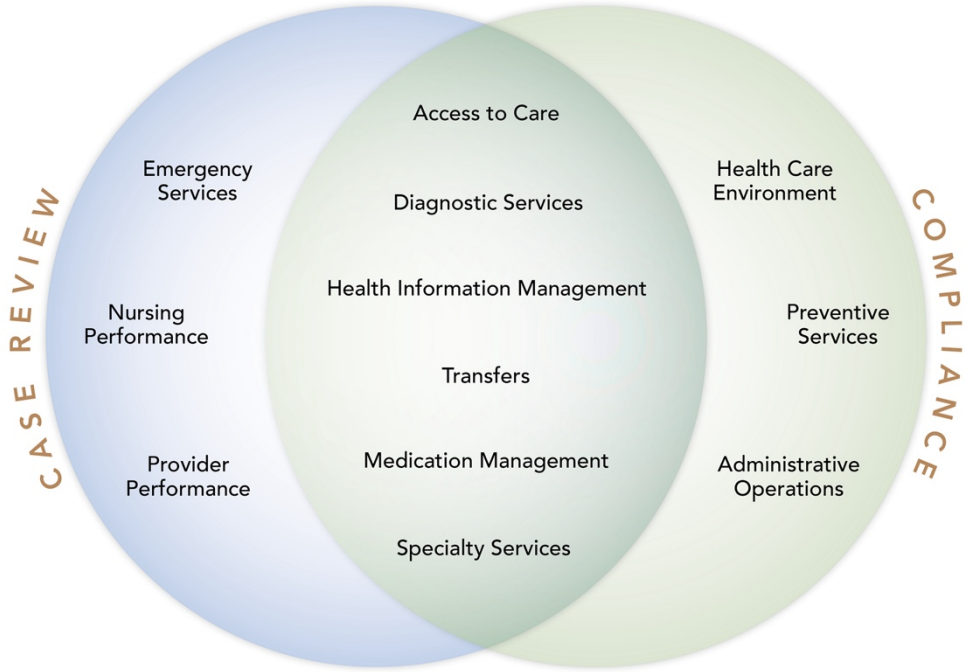
The OIG offers no recommendations for this indicator.

# Appendix A. Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We 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, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates the delivery of medical care 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.

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure A–1 below depicts the intersection of case review and compliance.

**Figure A–1. Inspection Indicator Rating Distribution for PVSP**




Source: The Office of the Inspector General medical inspection results.

## Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 6 medical inspections. Below, Table A–1 provides important definitions that describe this process.

**Table A–1. Case Review Definitions**

| | |
|---|---|
| ***Case, Sample, or Patient*** | The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews. |
| ***Comprehensive 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. |
| ***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 noncompliance, elevated risk of patient harm, or both. |
| ***Adverse Event*** | An event that caused harm to the patient. |

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinical analysts use a standardized sampling methodology to select most of the case review samples. A randomizer is used when applicable.

For most basic institutions, the OIG samples 20 comprehensive physician review cases. For institutions with larger high-risk populations, 25 cases are sampled. For the California Health Care Facility, 30 cases are sampled.

## *Case Review Sampling Methodology*

We obtain a substantial amount of health care data from the inspected institution and from CCHCS. Our analysts then apply filters to identify clinically complex patients with the highest need for medical services. These filters include patients classified by CCHCS with high medical risk, patients requiring hospitalization or emergency medical services, patients arriving from a county jail, patients transferring to and from other departmental institutions, patients with uncontrolled diabetes or uncontrolled anticoagulation levels, patients requiring specialty services or who died or experienced a sentinel event (unexpected occurrences resulting in high risk of, or actual, death or serious injury), patients requiring specialized medical housing placement, patients requesting medical care through the sick call process, and patients requiring prenatal or postpartum care.

After applying filters, analysts follow a predetermined protocol and select samples for clinicians to review. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

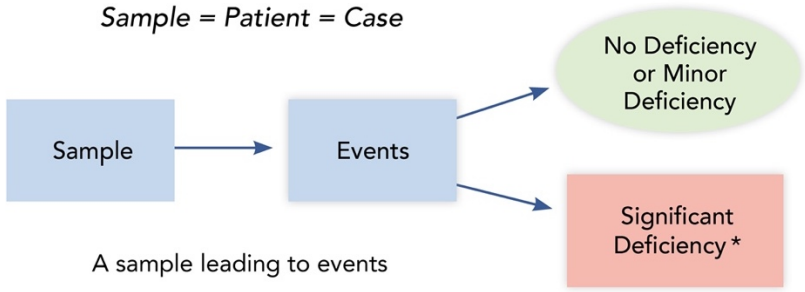
## *Case Review Testing Methodology*

An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review *events*. Our clinicians also record medical errors, which we refer to as case review *deficiencies*.

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an *adverse event*. On the next page, Figure A–2 depicts the possibilities that can lead to these different events. After the clinician inspectors review all the cases, they analyze the deficiencies, then summarize their findings in one or more of the health care indicators in this report.

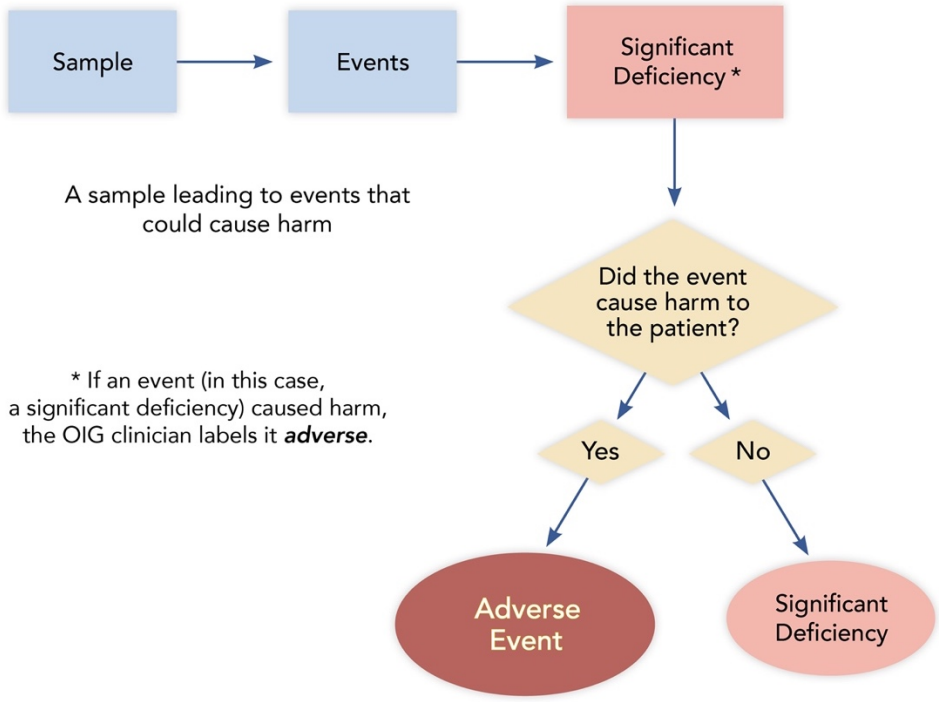
**Figure A–2. Case Review Testing**

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




***Deficiencies***

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



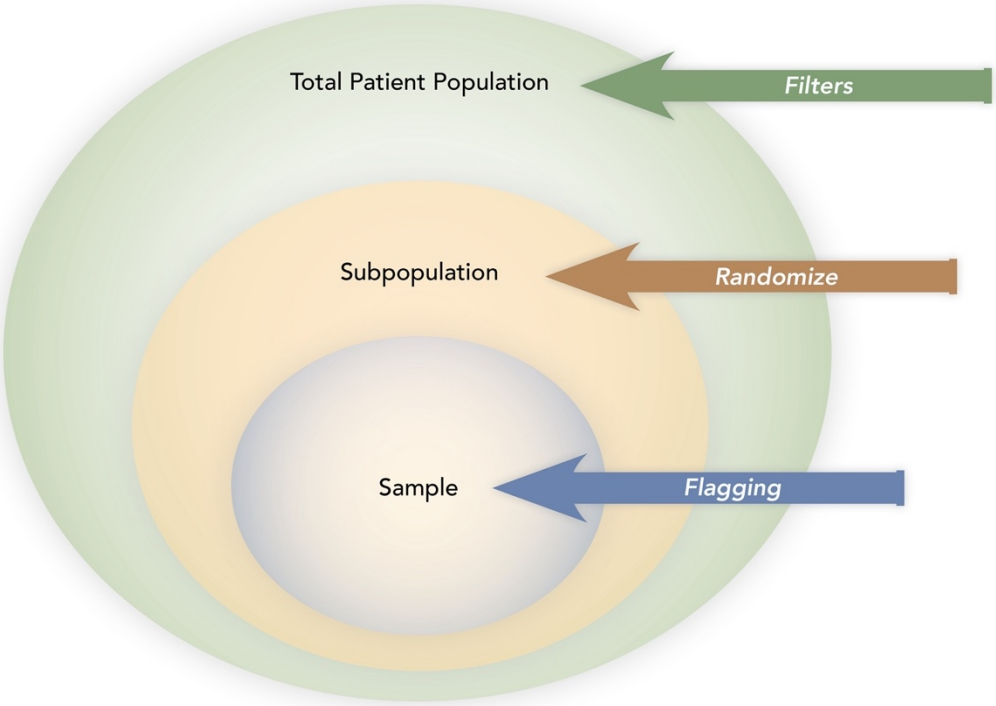

Source: The Office of the Inspector General medical inspection analysis.

# Compliance Testing

## *Compliance Sampling Methodology*

Our analysts identify samples for both our case review inspectors and compliance inspectors. Analysts follow a detailed selection methodology. For most compliance questions, we use sample sizes of approximately 25 to 30. Figure A–3 below depicts the relationships and activities of this process.

**Figure A–3. Compliance Sampling Methodology**




Source: The Office of the Inspector General medical inspection analysis.

## *Compliance Testing Methodology*

Our inspectors answer a set of predefined medical inspection tool (MIT) questions to determine the institution's compliance with CCHCS policies and procedures. Our nurse inspectors assign a Yes or a No answer to each scored question.

OIG headquarters nurse inspectors review medical records to obtain information, allowing them to answer most of the MIT questions. Our regional nurses visit and inspect each institution. They interview health care staff, observe medical processes, test the facilities and clinics, review employee records, logs, medical grievances, death reports, and other

documents, and obtain information regarding plant infrastructure and local operating procedures.

### *Scoring Methodology*

Our compliance team calculates the percentage of all Yes answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: ***proficient*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

## Indicator Ratings and the Overall Medical Quality Rating

To reach an overall quality rating, our inspectors collaborate and examine all the inspection findings. We consider the case review and the compliance testing results for each indicator. After considering all the findings, our inspectors reach consensus on an overall rating for the institution.

# Appendix B. Case Review Data

## Table B–1. PVSP Case Review Sample Sets

| Sample Set | Total |
|---|---|
| Death Review/Sentinel Events | 2 |
| Diabetes | 4 |
| Emergency Services – CPR | 1 |
| Emergency Services – Non-CPR | 2 |
| High Risk | 2 |
| Hospitalization | 6 |
| Intra-system Transfers-In | 3 |
| Intra-system Transfers-Out | 3 |
| RN Sick Call | 18 |
| Specialty Services | 4 |
| | **45** |

## Table B–2. PVSP Case Review Chronic Care Diagnoses

| Diagnosis | Total |
|---|---|
| Arthritis/Degenerative Joint Disease | 3 |
| Asthma | 1 |
| COPD | 1 |
| Cardiovascular Disease | 1 |
| Chronic Kidney Disease | 1 |
| Chronic Pain | 6 |
| Cirrhosis/End Stage Liver Disease | 2 |
| Coccidioidomycosis | 3 |
| COVID-19 | 1 |
| Diabetes | 4 |
| Gastroesophageal Reflux Disease | 4 |
| Hepatitis C | 11 |
| Hyperlipidemia | 9 |
| Hypertension | 7 |
| Mental Health | 13 |
| Seizure Disorder | 3 |
| Sleep Apnea | 2 |
| Substance Abuse | 12 |
| Thyroid Disease | 2 |
| | **86** |

## Table B–3. PVSP Case Review Events by Program

| Program | Total |
|---|---|
| Diagnostic Services | 220 |
| Emergency Care | 33 |
| Hospitalization | 20 |
| Intra-system Transfers-In | 11 |
| Intra-system Transfers-Out | 6 |
| Not Specified | 3 |
| Outpatient Care | 354 |
| Specialty Services | 62 |
| | 709 |

## Table B–4. PVSP Case Review Sample Summary

| | |
|---|---|
| MD Reviews Detailed | 20 |
| MD Reviews Focused | 0 |
| RN Reviews Detailed | 12 |
| RN Reviews Focused | 25 |
| Total Reviews | 57 |
| Total Unique Cases | 45 |
| Overlapping Reviews (MD & RN) | 12 |

# Appendix C. Compliance Sampling Methodology

## *Pleasant Valley State Prison*

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Access to Care* | | | | |
| MIT 1.001 | Chronic Care Patients | 25 | Master Registry | • Chronic care conditions (at least one condition per patient—any risk level)<br>• Randomize |
| MIT 1.002 | Nursing Referrals | 25 | OIG Q: 6.001 | • See Transfers |
| MITs 1.003–006 | Nursing Sick Call (6 per clinic) | 30 | Clinic Appointment List | • Clinic (each clinic tested)<br>• Appointment date (2–9 months)<br>• Randomize |
| MIT 1.007 | Returns From Community Hospital | 9 | OIG Q: 4.005 | • See Health Information Management (Medical Records) (returns from community hospital) |
| MIT 1.008 | Specialty Services Follow-Up | 45 | OIG Q: 14.001, 14.004 & 14.007 | • See Specialty Services |
| MIT 1.101 | Availability of Health Care Services Request Forms | 6 | OIG on-site review | • Randomly select one housing unit from each yard |
| *Diagnostic Services* | | | | |
| MITs 2.001–003 | Radiology | 10 | Radiology Logs | • Appointment date (90 days–9 months)<br>• Randomize<br>• Abnormal |
| MITs 2.004–006 | Laboratory | 10 | Quest | • Appt. date (90 days–9 months)<br>• Order name (CBC or CMPs only)<br>• Randomize<br>• Abnormal |
| MITs 2.007–009 | Laboratory STAT | 2 | Quest | • Appt. date (90 days–9 months)<br>• Order name (CBC or CMPs only)<br>• Randomize<br>• Abnormal |
| MITs 2.010–012 | Pathology | 10 | InterQual | • Appt. date (90 days–9 months)<br>• Service (pathology related)<br>• Randomize |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Health Information Management (Medical Records)* | | | | |
| MIT 4.001 | Health Care Services Request Forms | 30 | OIG Qs: 1.004 | • Nondictated documents<br>• First 20 IPs for MIT 1.004 |
| MIT 4.002 | Specialty Documents | 45 | OIG Qs: 14.002, 14.005 & 14.008 | • Specialty documents<br>• First 10 IPs for each question |
| MIT 4.003 | Hospital Discharge Documents | 9 | OIG Q: 4.005 | • Community hospital discharge documents<br>• First 20 IPs selected |
| MIT 4.004 | Scanning Accuracy | 24 | Documents for any tested inmate | • Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No) |
| MIT 4.005 | Returns From Community Hospital | 9 | CADDIS Off-site Admissions | • Date (2–8 months)<br>• Most recent 6 months provided (within date range)<br>• Rx count<br>• Discharge date<br>• Randomize |
| *Health Care Environment* | | | | |
| MITs 5.101–105<br>MITs 5.107–111 | Clinical Areas | 9 | OIG inspector on-site review | • Identify and inspect all on-site clinical areas. |
| *Transfers* | | | | |
| MITs 6.001–003 | Intra-system Transfers | 25 | SOMS | • Arrival date (3–9 months)<br>• Arrived from (another departmental facility)<br>• Rx count<br>• Randomize |
| MIT 6.101 | Transfers Out | 3 | OIG inspector on-site review | • R&R IP transfers with medication |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Pharmacy and Medication Management* | | | | |
| MIT 7.001 | Chronic Care Medication | 25 | OIG Q: 1.001 | See Access to Care<br>• At least one condition per patient—any risk level<br>• Randomize |
| MIT 7.002 | New Medication Orders | 25 | Master Registry | • Rx count<br>• Randomize<br>• Ensure no duplication of IPs tested in MIT 7.001 |
| MIT 7.003 | Returns From Community Hospital | 9 | OIG Q: 4.005 | • See Health Information Management (Medical Records) (returns from community hospital) |
| MIT 7.004 | RC Arrivals—Medication Orders | N/A at this institution | OIG Q: 12.001 | • See Reception Center |
| MIT 7.005 | Intra-facility Moves | 25 | MAPIP transfer data | • Date of transfer (2–8 months)<br>• To location/from location (yard to yard and to/from ASU)<br>• Remove any to/from MHCB<br>• NA/DOT meds (and risk level)<br>• Randomize |
| MIT 7.006 | En Route | 3 | SOMS | • Date of transfer (2–8 months)<br>• Sending institution (another departmental facility)<br>• Randomize<br>• NA/DOT meds |
| MITs 7.101–103 | Medication Storage Areas | Varies by test | OIG inspector on-site review | • Identify and inspect clinical & med line areas that store medications |
| MITs 7.104–107 | Medication Preparation and Administration Areas | Varies by test | OIG inspector on-site review | • Identify and inspect on-site clinical areas that prepare and administer medications |
| MITs 7.108–111 | Pharmacy | 1 | OIG inspector on-site review | • Identify & inspect all on-site pharmacies |
| MIT 7.112 | Medication Error Reporting | 12 | Medication error reports | • All medication error reports with Level 4 or higher<br>• Select total of 25 medication error reports (recent 12 months) |
| MIT 7.999 | Restricted Unit KOP Medications | 8 | On-site active medication listing | • KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Prenatal and Postpartum Care* | | | | |
| MITs 8.001–007 | Recent Deliveries | N/A at this institution | OB Roster | • Delivery date (2–12 months)<br>• Most recent deliveries (within date range) |
| | Pregnant Arrivals | N/A at this institution | OB Roster | • Arrival date (2–12 months)<br>• Earliest arrivals (within date range) |
| *Preventive Services* | | | | |
| MITs 9.001–002 | TB Medications | 25 | Maxor | • Dispense date (past 9 months)<br>• Time period on TB meds (3 months or 12 weeks)<br>• Randomize |
| MIT 9.003 | TB Evaluation, Annual Screening | 25 | SOMS | • Arrival date (at least 1 year prior to inspection)<br>• Birth month<br>• Randomize |
| MIT 9.004 | Influenza Vaccinations | 25 | SOMS | • Arrival date (at least 1 year prior to inspection)<br>• Randomize<br>• Filter out IPs tested in MIT 9.008 |
| MIT 9.005 | Colorectal Cancer Screening | 25 | SOMS | • Arrival date (at least 1 year prior to inspection)<br>• Date of birth (51 or older)<br>• Randomize |
| MIT 9.006 | Mammogram | N/A at this institution | SOMS | • Arrival date (at least 2 yrs. prior to inspection)<br>• Date of birth (age 52–74)<br>• Randomize |
| MIT 9.007 | Pap Smear | N/A at this institution | SOMS | • Arrival date (at least three yrs. prior to inspection)<br>• Date of birth (age 24–53)<br>• Randomize |
| MIT 9.008 | Chronic Care Vaccinations | 25 | OIG Q: 1.001 | • Chronic care conditions (at least 1 condition per IP—any risk level)<br>• Randomize<br>• Condition must require vaccination(s) |
| MIT 9.009 | Valley Fever | 25 | Cocci transfer status report | • Reports from past 2–8 months<br>• Institution<br>• Ineligibility date (60 days prior to inspection date)<br>• All |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Reception Center* | | | | |
| MITs 12.001–008 | RC | N/A at this institution | SOMS | • Arrival date (2–8 months)<br>• Arrived from (county jail, return from parole, etc.)<br>• Randomize |
| *Specialized Medical Housing* | | | | |
| MITs 13.001–004 | Specialized Health Care Housing Unit | N/A at this institution | CADDIS | • Admit date (2–8 months)<br>• Type of stay (no MH beds)<br>• Length of stay (minimum of 5 days)<br>• Rx count<br>• Randomize |
| MITs 13.101 - 102 | Call Buttons | All | OIG inspector on-site review | • Specialized Health Care Housing<br>• Review by location |
| *Specialty Services* | | | | |
| MITs 14.001–003 | High-Priority Initial and Follow-Up RFS | 15 | Specialty Services Appointments | • Approval date (3–9 months)<br>• Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services<br>• Randomize |
| MITs 14.004–006 | Medium-Priority Initial and Follow-Up RFS | 15 | Specialty Services Appointments | • Approval date (3–9 months)<br>• Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services<br>• Randomize |
| MITs 14.007–009 | Routine-Priority Initial and Follow-Up RFS | 15 | Specialty Services Appointments | • Approval date (3–9 months)<br>• Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical |

| | | | | |
|---|---|---|---|---|
| | | | | therapy, physiatry, podiatry, and radiology services<br>• Randomize |
| MIT 14.010 | Specialty Services Arrivals | 20 | Specialty Service Arrivals | • Arrived from (other departmental institution)<br>• Date of transfer (3–9 months)<br>• Randomize |
| MITs 14.011–012 | Denials | 20 | InterQual | • Review date (3–9 months)<br>• Randomize |
| | | N/A | IUMC/MAR Meeting Minutes | • Meeting date (9 months)<br>• Denial upheld<br>• Randomize |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Administrative Operations* | | | | |
| MIT 15.001 | Adverse/Sentinel events (ASE) | 0 | Adverse/sentinel events report | • Adverse/Sentinel events (2–8 months) |
| MIT 15.002 | QMC Meetings | 6 | Quality Management Committee meeting minutes | • Meeting minutes (12 months) |
| MIT 15.003 | EMRRC | 12 | EMRRC meeting minutes | • Monthly meeting minutes (6 months) |
| MIT 15.004 | LGB | N/A at this institution | LGB meeting minutes | • Quarterly meeting minutes (12 months) |
| MIT 15.101 | Medical Emergency Response Drills | 3 | On-site summary reports & documentation for ER drills | • Most recent full quarter<br>• Each watch |
| MIT 15.102 | Institutional Level Medical Grievances | 10 | On-site list of grievances/closed grievance files | • Medical grievances closed (6 months) |
| MIT 15.103 | Death Reports | 0 | Institution-list of deaths in prior 12 months | • Most recent 10 deaths<br>• Initial death reports |
| MIT 15.104 | Nursing Staff Validations | 10 | On-site nursing education files | • On duty one or more years<br>• Nurse administers medications<br>• Randomize |
| MIT 15.105 | Provider Annual Evaluation Packets | 6 | On-site provider evaluation files | • All required performance evaluation documents |
| MIT 15.106 | Provider Licenses | 7 | Current provider listing (at start of inspection) | • Review all |
| MIT 15.107 | Medical Emergency Response Certifications | All | On-site certification tracking logs | • All staff<br>◦ Providers (ACLS)<br>◦ Nursing (BLS/CPR)<br>• Custody (CPR/BLS) |
| MIT 15.108 | Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications | All | On-site tracking system, logs, or employee files | • All required licenses and certifications |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Administrative Operations* | | | | |
| MIT 15.109 | Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations | All | On-site listing of provider DEA registration #s & pharmacy registration document | • All DEA registrations |
| MIT 15.110 | Nursing Staff New Employee Orientations | All | Nursing staff training logs | • New employees (hired within last 12 months) |
| MIT 15.998 | Death Review Committee | 0 | OIG summary log: deaths | • Between 35 business days & 12 months prior<br>• California Correctional Health Care Services death reviews |

# California Correctional Health Care Services' Response

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October 14, 2022

Amarik Singh, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The Office of the Receiver has reviewed the draft Medical Inspection Report for Pleasant Valley State Prison (PVSP) conducted by the Office of the Inspector General (OIG) from May to October 2021. 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) 896-6780.

Sincerely,

DocuSigned by:
Robin Hart
8052220F6D6A411...

Robin Hart
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Jackie Clark, Deputy Director, Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Regional Health Care Executive, Region II, CCHCS
Regional Deputy Medical Executive, Region II, CCHCS
Regional Nursing Executive, Region II, CCHCS
Chief Executive Officer, PVSP
Katherine Tebrock, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Misty Polasik, Staff Services Manager I, OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
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# Cycle 6

# Medical Inspection Report

*for*

# Pleasant Valley State Prison


OFFICE *of the*
INSPECTOR GENERAL

*Amarik K. Singh*
Inspector General

*Neil Robertson*
Chief Deputy Inspector General



STATE *of* CALIFORNIA
November 2022


OIG