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OIG | OFFICE of the INSPECTOR GENERAL

Independent Prison Oversight

February 2024

Cycle 7

Medical Inspection Report

*Valley State
Prison*



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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 people¹ in the California Department of Corrections and Rehabilitation (the department).²

In Cycle 7, the OIG continues to apply the same assessment methodologies used in Cycle 6, 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).⁴ We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion 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.

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 individual or system errors. The review assesses the institution's medical care on both individual and system levels. The OIG rates the indicators **proficient**, **adequate**, or **inadequate**.

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

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 (HEDIS) 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 of a patient needing immediate care, we notify the institution's chief executive officer.

As we did during Cycle 6, our office continues 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 the Cycle 7 inspection of Valley State Prison, the institution had been delegated back to the department by the receiver.

We completed our seventh inspection of VSP, and this report presents our assessment of the health care provided at this institution during the inspection period from June 2022 to November 2022.⁶

Valley State Prison (VSP) is located in Chowchilla and houses primarily Level II General Population incarcerated persons and those requiring sensitive needs yard (SNY) placements. VSP is designated as a *basic care institution*, providing general medical care through its five medical clinics which handle nonurgent requests for medical services. Patients needing urgent or emergent care are treated in its triage and treatment area (TTA). Additional services are provided in the outpatient housing unit (OHU), through special services, and via telemedicine. VSP provides care to patients in the mental health delivery system at the Enhanced Outpatient Program (EOP) and serves as a reentry hub for incarcerated persons for needs-based rehabilitative services.⁷

⁶ Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews that occurred between January 2022 and July 2022, emergency cardiopulmonary resuscitation (CPR) reviews between February 2022 and June 2022, and transfer reviews between May 2022 and September 2022.

⁷ As of July 18, 2023, the department reported on its public tracker that 85% of VSP's incarcerated population was fully vaccinated while 76% of VSP's staff was fully vaccinated:
<http://www.cdcr.ca.gov/covid19/population-status-tracking/>.

Summary

We completed the Cycle 7 inspection of VSP in April 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between June 2022 and November 2022.

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



Table 1. VSP Summary Table

Health Care Indicators	Ratings			Change Since Cycle 6*
	Proficient	Adequate	Inadequate	
	Blue	Green	Red	
	Cycle 7 Ratings			
	Case Review	Compliance	Overall	
Access to Care	Proficient	Proficient	Proficient	=
Diagnostic Services	Adequate	Inadequate	Inadequate	↓
Emergency Services	Adequate	N/A	Adequate	=
Health Information Management	Inadequate	Proficient	Adequate	=
Health Care Environment	N/A	Inadequate	Inadequate	=
Transfers	Adequate	Inadequate	Inadequate	=
Medication Management	Adequate	Inadequate	Inadequate	=
Prenatal and Postpartum Care	N/A	N/A	N/A	N/A
Preventive Services	N/A	Inadequate	Inadequate	=
Nursing Performance	Adequate	N/A	Adequate	=
Provider Performance	Inadequate	N/A	Inadequate	↓
Reception Center	N/A	N/A	N/A	N/A
Specialized Medical Housing	Adequate	Inadequate	Adequate	=
Specialty Services	Adequate	Inadequate	Inadequate	↓
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 6 and Cycle 7. 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 379 patient records and 1,137 data points, and used the data to answer 91 policy questions. In addition, we observed VSP's processes during an on-site inspection in January 2023. Table 2 below lists VSP average scores from Cycles 6 and 7.

Table 2. VSP Policy Compliance Scores

		Scoring Ranges	
		100% – 85.0%	84.9% – 75.0% 74.9% – 0
Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score	
		Cycle 6	Cycle 7
1	Access to Care	92.0%	91.9%
2	Diagnostic Services	63.0%	58.1%
4	Health Information Management	76.0%	87.0%
5	Health Care Environment	69.0%	43.0%
6	Transfers	66.0%	56.5%
7	Medication Management	70.0%	57.0%
8	Prenatal and Postpartum Care	N/A	N/A
9	Preventive Services	73.0%	72.8%
12	Reception Center	N/A	N/A
13	Specialized Medical Housing	83.0%	55.6%
14	Specialty Services	89.0%	69.8%
15	Administrative Operations	83.0%	77.6%

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 811 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in April 2023 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 none **proficient**, 14 **adequate**, and six **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 13 health care indicators.⁸ Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures designed to catch and resolve mistakes that may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in the VSP Summary Table.

In January 2023, the Health Care Services Master Registry showed VSP had a total population of 2,971. A breakdown of the medical risk level of the VSP population as determined by the department is set forth in Table 3 below.⁹

Table 3. VSP Master Registry Data as of January 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	299	10.1%
High 2	418	14.1%
Medium	1,306	44.0%
Low	948	31.9%
Total	2,971	100.0%

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 1-10-23.

⁸ The indicators for **Reception Center** and **Prenatal and Postpartum Care** did not apply to VSP.

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, VSP had no vacant executive leadership positions, 1.5 primary care provider vacancies, no vacant nursing supervisor positions, and 8.5 nursing staff vacancies.

Table 4. VSP Health Care Staffing Resources as of January 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	8.5	10.7	88.5	112.7
Filled by Civil Service	5.0	7.0	11.0	80.0	103.0
Vacant	0	1.5	-0.3	8.5	9.7
Percentage Filled by Civil Service	100.0%	82.4%	102.8%	90.4%	91.4%
Filled by Telemedicine	0	2.0	0	0	2.0
Percentage Filled by Telemedicine	0	23.5%	0	0	1.8%
Filled by Registry	0	3.0	0	14.0	17.0
Percentage Filled by Registry	0	35.3%	0	15.8%	15.1%
Total Filled Positions	5.0	12.0	11.0	94.0	122.0
Total Percentage Filled	100.0%	141.2%	102.8%	106.2%	108.3%
Appointments in Last 12 Months	1.0	3.0	3.0	15.0	22.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	1.0	1.0	2.0	4.0
Adjusted Total: Filled Positions	5.0	11.0	10.0	92.0	118.0
Adjusted Total: Percentage Filled	100.0%	129.4%	93.5%	104.0%	104.7%

* 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 7 medical inspection preinspection questionnaire received on January 10, 2023, 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 VSP during the Cycle 7 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to VSP. Of these 10 indicators, OIG clinicians rated one **proficient**, seven **adequate**, and two **inadequate**. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, none was **proficient**, 14 were **adequate** and six were **inadequate**. In the 811 events reviewed, there were 268 deficiencies, 44 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 VSP:

- Staff provided excellent overall access to providers and nurses.
- Staff provided excellent overall access to specialty services.
- Staff provided good emergency response and assessments.

Our clinicians found the following weaknesses at VSP:

- The providers did not consistently review medical records regularly and thoroughly, or consistently document their medical care.
- The providers did not consistently review test results and communicate the results to the patients timely.
- The staff did not consistently forward specialty reports to the physician.

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

- EMRRC did not always thoroughly audit emergency events, identify all deficiencies, and ensure all required reviewers complete the clinical reviews.
- Staff did not consistently provide chronic care medication timely.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to VSP. Of these 10 indicators, our compliance inspectors rated two *proficient*, one *adequate*, and seven *inadequate*. We tested policy compliance in **Health Care Environment, Preventive Services, and Administrative Operations** as these indicators do not have a case review component.

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

- Nursing staff at VSP reviewed health care services request forms and conducted face-to-face encounters within required time frames. In addition, VSP housing units contained adequate supplies of health care request forms.
- Patients returning from outside community hospitals or specialty service appointments saw their primary care providers within the specified time frames.
- Medical staff performed well in scanning specialty service reports, community hospital discharge reports, and requests for health care services into patients' electronic medical records within required time frames.

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

- Medical clinics had multiple medical supplies that were expired.
- Health care staff did not follow hand hygiene precautions before or after patient encounters, and during medication administration.
- Nursing staff did not regularly inspect emergency response bags and treatment carts.
- Patients did not always receive their chronic care medications within required time frames. There was poor medication continuity for patients returning from hospitalizations, for patients admitted to specialized medical housing, and for patients transferring into and laying over at VSP.
- VSP did not perform well in timely providing preapproved specialty services for patients who transferred into the institution.
- VSP performed poorly in retrieving specialty service reports, and providers did not always review these reports within the required time frame.

- 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.

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 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 7. 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 California Medi-Cal and Kaiser Medi-Cal HEDIS scores for one diabetic measure to use in conducting our analysis, and we present that here for comparison.

HEDIS Results

We used population-based metrics in considering VSP's performance to assess the macroscopic view of the institution's health care delivery. VSP's results compared favorably with those found in State health plans for poor HbA1c control. We list the applicable HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—VSP's rate of performance was very good in the one diabetic measure that has statewide comparative data: poor HbA1c control.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include these data for informational purposes. VSP had a 67 percent influenza immunization rate for adults 18 to 64 years old and a 90 percent influenza immunization rate for adults 65 years of age and older.¹¹ The pneumococcal vaccine rate was 92 percent.¹²

¹¹ The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result.

¹² The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV 15, and PCV 20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than the one in which the patient was currently housed during the inspection period.

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. VSP had an 81 percent colorectal cancer screening rate.

Table 5. VSP Results Compared With State HEDIS Scores

HEDIS Measure	Cycle 7 Results*	California Medi-Cal†	Kaiser NorCal Medi-Cal†	Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%)‡,§	5%	38%	28%	20%
HbA1c Control (< 8.0%)‡	87%	–	–	–
Blood Pressure Control (< 140/90)‡	86%	–	–	–
Eye Examinations	77%	–	–	–
Influenza–Adults (18–64)	67%	–	–	–
Influenza–Adults (65+)	90%	–	–	–
Pneumococcal–Adults (65+)	92%	–	–	–
Colorectal Cancer Screening	81%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in January 2023 by reviewing medical records from a sample of VSP'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*, dated July 1, 2021–June 30, 2022 (published April 2023); <https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2021-22-MCMC-EQR-TR-VOL1-F1.pdf>.

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

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

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 VSP's performance, we offer the following recommendations to the department:

Diagnostic Services

- Medical leadership should ensure providers endorse all diagnostic results timely and communicate the results with patients.
- The department should consider developing an electronic solution to ensure providers create patient letters at the time of endorsement and patient results letters automatically populate accurately with all required elements per CCHCS policy.
- Medical leadership should determine the root cause of challenges with untimely collecting, receiving, notifying, and endorsing STAT laboratory results and implement remedial measures as appropriate to ensure they are performed within required time frames.

Emergency Services

- Medical and nursing leadership should ensure the Emergency Medical Response Review Committee (EMRRC) thoroughly audits emergency events, identifies all deficiencies, and ensures all required reviewers complete the clinical reviews.

Health Information Management

- Medical leadership should identify challenges in scanning, labeling, and including medical records in the correct patient's file, and implement remedial measures as appropriate.
- The department should develop an electronic hard stop to not allow staff to complete a report scanning task until the report has been forwarded to the provider for review or endorsement.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Executive leadership should consider performing random spot checks to ensure medical supply storage areas, which were located outside the clinics, store medical supplies adequately.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure these bags and carts are regularly inventoried and sealed.

Transfers

- Nursing leadership should ensure receiving and release (R&R) nurses confirm all patients transferring out of the institution have required medications, transfer documents, and assigned durable medical equipment (DME).
- Medical, nursing, and pharmacy leadership should ensure newly arrived patients and patients returning from a hospitalization receive recommended medications to ensure medication continuity.
- Nursing leadership should educate R&R nurses to thoroughly complete the initial health screening, including answering all questions and documenting an explanation for each “yes” answer, documenting a complete vital signs check as part of the patient’s initial health screening assessment, and completing the initial health screening form prior to the patient being placed in housing.

Medication Management

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients and staff document in EHRS as described in CCHCS policy and procedures.¹³

Preventive Services

- Nursing leadership should consider developing and implementing measures to ensure nursing staff monitor patients who are receiving TB medications according to CCHCS guidelines.
- Medical leadership should analyze the challenges related to the untimely provision of preventative vaccines and implement remedial measures as warranted.

Nursing Performance

- Nursing leadership should ensure thorough assessments are completed for all face-to-face encounters.

Provider Performance

- Medical leadership should ascertain causative factors in the untimely provider review of test results. Medical leadership should implement remedial measures as appropriate.
- Medical leadership should remind providers to fully document their co-consultations with nurses in the EHRS.

¹³ EHRS is the initialism for the department’s electronic health record system.

- Medical leadership should consider reminding providers to review the blood-sugar levels from finger-stick tests of diabetic patients at each visit.

Specialized Medical Housing

- The institution should consider determining and evaluating causative factors related to the untimely provisions of medications and implement remedial measures as appropriate.
- The nursing leadership should provide training to the OHU nurses about the institution's local operating procedures for the call light communication system.

Specialty Services

- Medical leadership should identify the root cause(s) of untimely completion of subsequent, specialty follow-up appointments for high and medium-priority services and implement remedial measures as appropriate.
- Medical leadership should identify the root cause(s) of untimely completion of transfer patients' specialty appointments and implement remedial measures as appropriate.
- Medical leadership should ascertain the challenges in the untimely receipt of specialty reports and the untimely provider review of these reports and implement remedial measures as appropriate.

Access to Care

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 calls, 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.

Overall
Rating
Proficient

Case Review
Rating
Proficient

Compliance
Score
Proficient
(91.9%)

Results Overview

Compared with Cycle 6, VSP maintained a **proficient** rating for both compliance and case review in Cycle 7. Overall, providers and nurses saw the patient timely when appointments were requested. There were a few cases in which patients did not receive their specialty appointments within the specified time frame, but after reviewing the details, we ultimately rated this indicator **proficient**.

Case Review and Compliance Testing Results

OIG clinicians reviewed 164 provider, nursing, urgent or emergent, specialty, and hospital events that required the institution to generate appointments. We identified two deficiencies relating to **Access to Care**, neither of which was significant.¹⁴

Access to Care Providers

VSP performed well in providing access to provider appointments. Compliance testing showed good access to chronic care follow-up appointments (MIT 1.001, 84.0%) and nursing to primary care provider referral appointments (MIT 1.005, 90.0%). Case review clinicians found no deficiencies in the scheduling of provider appointments. Due to movement restrictions related to the COVID-19 pandemic, we considered most providers' chart reviews for nonurgent, low- or medium-risk chronic care appointments in patients who had stable chronic conditions as acceptable alternatives to face-to-face or telephonic appointments.

Access to Specialized Medical Housing Providers

VSP provided sufficient access to specialized medical housing providers. The compliance testing determined providers completed a written history and physical examination within the required time frame for most of the review period (MIT 13.002, 77.8%). The case review clinicians found no deficiencies related to access to specialized medical housing providers.

¹⁴ Deficiencies occurred in cases 10 and 16.

Access to Clinic Nurses

VSP performed excellently in access to nurse sick calls and provider-to-nurse referrals. Compliance testing found nurses always triaged sick call requests the same day they received them (MIT 1.003, 100%), and performed face-to-face appointments timely (MIT 1.004, 100%). Our clinicians assessed 48 nursing sick call requests and identified no deficiencies related to clinic nurse access.

Access to Specialty Services

VSP performed well in referrals to specialty services. Compliance testing revealed a good completion rate of high-priority (MIT 14.001, 86.7%), medium-priority (MIT 14.004, 86.7%), routine-priority (MIT 14.007, 86.7%), and subsequent follow-up to routine-priority (MIT 14.009, 88.9%) appointments. In contrast, compliance testing found patients did not receive subsequent specialty follow-up appointments within the specified time frames for high-priority (MIT 14.003, 57.1%) and medium-priority (MIT 14.006, 50.0%) services. Case review clinicians found most specialty appointments took place within requested time frames; we identified only two deficiencies, both of which were not considered significant.¹⁵

Follow-Up After Specialty Services

Compliance testing revealed most provider appointments, after specialty services, occurred within required time frames (MIT 1.008, 85.0%). Case review did not identify any deficiencies related to provider follow-up after specialty services.

Follow-Up After Hospitalization

VSP provided excellent access to provider follow-up appointments for patients who were discharged from a community hospital (MIT 1.007, 100%). Case review did not identify any deficiencies related to provider follow-up after hospitalization.

Follow-Up After Urgent or Emergent Care (TTA)

Providers always saw their patients following a triage and treatment area (TTA) event as requested. OIG clinicians assessed 25 TTA events and identified no delays in provider follow-up appointments.

Follow-Up After Transferring Into VSP

Compliance testing showed sufficient access to intake appointments for newly arrived patients (MIT 1.002, 76.0%). Case reviewers did not find any deficiencies in this area; however, we only reviewed five cases in which patients transferred from another institution.

¹⁵ Deficiencies occurred in cases 10 and 16.

Clinician On-Site Inspection

VSP had four main clinics: A, B, C, and D, and each clinic had two providers. Clinics A, C, and D were staffed with one telemedicine and one on-site provider. Clinic B was staffed with two on-site providers. At the time of the on-site inspection, Clinic B was temporarily housed in the infirmary area while renovation of the permanent clinic space was nearing completion. All the clinics were staffed with registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs). In addition to the provider line, staff members all had their own lines. MAs reported their providers had no current backlogs.

The OIG clinicians attended morning huddles, which were well attended by the patient care team and staff. The morning huddles lasted about 15 minutes and were satisfactorily organized. OIG clinicians met with the scheduling supervisor who reported the institution had four office technician vacancies during the case review period, and three providers were out on long-term sick leave (ranging from three to six months). In addition, the scheduling supervisor provided a local operating policy for scheduling and access to care in place during the case review period and stated it was similar to the policy from CCHCS. The scheduling supervisor also mentioned, while it was challenging to adhere to the policy, as directions sometimes were changed daily, providers accepted the changes.

Compliance Testing Results

Compliance On-Site Inspection and Discussion

Patients had access to health care services request forms in all six housing units inspected (MIT 1.101, 100%).

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) *	19	6	0	76.0%
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) *	30	0	0	100%
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) *	9	1	20	90.0%
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) *	0	0	30	N/A
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	21	0	0	100%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	34	6	5	85.0%
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): 91.9%				

* 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 (prior to 07/2022) or five working days (effective 07/2022)? (12.004) *	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002) *	7	2	0	77.8%
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) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	4	3	8	57.1%
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) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	1	1	13	50.0%
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) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	8	1	6	88.9%

* 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.

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 7, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Results Overview

VSP had a mixed performance in this indicator. Compliance testing showed an inadequate rating while case review analysis resulted in an adequate rating. The factors that adversely affected the compliance score were related to laboratory (STAT), radiology, and pathology testing. The institution did not collect and receive results of STAT laboratory tests timely, the health care team did not notify the providers, and the providers did not endorse the results within required time frames. The providers' performance in timely communication of radiology, laboratory, and pathology results was also poor. After reviewing all aspects, we rated this indicator *inadequate*.

Overall
Rating
Inadequate

Case Review
Rating
Adequate

Compliance
Score
**Inadequate
(58.1%)**

Case Review and Compliance Testing Results

The OIG clinicians reviewed 214 diagnostic-related events and found 93 deficiencies, eight of which were significant.¹⁶ Of the 93 deficiencies, 84 related to health information management, and nine related to the noncompletion or delayed completion of ordered tests.¹⁷

Most of the deficiencies were due to patient notification letters either missing some of the required elements or not being sent to patients at all. Although the case reviewers identified a high number of these deficiencies, we determined these deficiencies did not significantly increase the risk of harm to patients.

Test Completion

VSP had a mixed performance in the timely completion of tests. Compliance testing showed very good performance completing radiology services (MIT 2.001, 80.0%) and laboratory services (MIT 2.004, 90.0%) within required time frames, but poor performance with completing STAT laboratory services (MIT 2.007, 30.0%). Case reviewers found only one significant deficiency related to test completion as described in the following case:

¹⁶ Deficiencies occurred in cases 1, 2, 6–17, 19, 20, 22, 23, 43, 44, and 45. Cases 1, 8, 10, and 16 had significant deficiencies.

¹⁷ Deficiencies related to health information management occurred in cases 1, 2, 6–16, 19, 20, and 43–45. Deficiencies related to noncompletion or delayed completion of ordered tests occurred in cases 6, 8, 10, 17, 19, 22, and 23.

- In case 8, the provider ordered the coagulation laboratory test to be performed as soon as possible; however, the laboratory specimen was collected more than a day later.

Health Information Management

VSP had a mixed performance in managing the results of diagnostic tests. Compliance testing showed providers performed very well in endorsing both radiology (MIT 2.002, 90.0%) and laboratory (MIT 2.005, 90.0%) results. In contrast, the case reviewers identified seven significant deficiencies related to late endorsement of test results.¹⁸ The following are two examples of severe deficiencies:

- In case 8, the provider reviewed the coagulation test results 47 days after the results were available.
- In case 10, the provider reviewed the proBNP laboratory test result 24 days after the results were available.¹⁹

The institution performed sufficiently in pathology report retrieval (MIT 2.010, 80.0%) and provider review of pathology reports (MIT 2.011, 77.8%). However, the providers only occasionally acknowledged, or nursing staff only intermittently notified providers of, STAT test results within required time frames (MIT 2.008, 40.0%). Similarly, the providers sometimes endorsed STAT laboratory test results timely (MIT 2.009, 70.0%). The case reviewers did not identify any deficiencies related to STAT or pathology test result retrieval or provider review.

Compliance testing revealed VSP providers performed poorly in communicating results to the patients. Providers sporadically communicated results from radiology studies (MIT 2.003, 20.0%) and laboratory studies (MIT 2.006, 30.0%), and never communicated results from pathology studies (MIT 2.012, zero) within the required time frames. Case review found 68 deficiencies related to provider communication of test results in the form of incomplete letters or letters not sent to the patient.²⁰

Additional discussion can be found under the **Health Information Management** indicator.

Clinician On-Site Inspection

The OIG clinicians interviewed the senior laboratory assistant and the correctional health services administrator (CHSA) who stated, during the case review period, the institution classified all laboratory work as urgent or emergent. This meant laboratory tests were drawn on a modified program because of COVID-19 protocols. In addition, the CHSA and senior laboratory

¹⁸ Significant deficiencies occurred in cases 1, 8, 10, and 16.

¹⁹ The laboratory test, proBNP, is used to diagnose and evaluate congestive heart failure.

²⁰ Deficiencies in patient notification letters were identified in cases 1, 2, 6, 8–12, 14–16, 19, 20, 43, 44, and 45. None of these deficiencies was considered significant.

assistant reported the institution had staff shortages due to COVID-19-related long-term sick leave among these staff members.

VSP did not have a centralized laboratory draw area as each clinic had a laboratory draw station. The senior laboratory assistant, CHSA, and clinic staff all cited this was a benefit, especially in yards with a high number of EOP patients who could not mix with the general population patients. VSP offered routine X-rays, computed tomography (CT) scans, and ultrasounds on site.²¹ Providers reported no issues with obtaining routine laboratory and on-site imaging studies. When asked about the availability of STAT labs, most providers indicated they had seldom ordered STAT labs and had not experienced any roadblocks to the timely completion of STAT laboratory tests when the need had arisen.

²¹ A CT scan is a computed, or computerized, tomography imaging scan.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	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) *	8	2	0	80.0%
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)	2	8	0	20.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	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 health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	3	7	0	30.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	3	7	0	30.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	4	6	0	40.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	7	3	0	70.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	7	2	1	77.8%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	8	2	0
Overall percentage (MIT 2): 58.1%				

* 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 providers endorse all diagnostic results timely and communicate the results with patients.
- The department should consider developing an electronic solution to ensure providers create patient letters at the time of endorsement and patient results letters automatically populate accurately with all required elements per CCHCS policy.
- Medical leadership should determine the root cause of challenges with untimely collecting, receiving, notifying, and endorsing STAT laboratory results and implement remedial measures as appropriate to ensure they are performed within required time frames.

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 primarily through case review.

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
(N/A)

Results Overview

VSP provided emergency care comparable to that rendered in Cycle 6. Nursing staff responded immediately to emergencies, frequently performed good patient assessments, interventions, and documentation. For patients who required CPR, custody and nursing staff worked together to initiate CPR and call 9-1-1. We identified opportunities for improvement with EMRRC. Overall, VSP medical and nursing staff provided good emergency care; therefore, we rated this indicator **adequate**.

Case Review Results

We reviewed 25 urgent or emergent events and found 20 emergency care deficiencies. Of these 20 deficiencies, six were significant.²²

Emergency Medical Response

Generally, VSP provided very good emergency care. Health care and custody staff responded immediately to medical emergencies throughout the institution. They initiated CPR, activated emergency medical services, and notified the TTA staff as required.

Cardiopulmonary Resuscitation Quality

VSP performed well in this area. Our OIG clinicians reviewed five cases in which patients required CPR.²³ Custody and nursing staff initiated CPR without delay, as well as notified emergency medical services and the TTA staff as required. We identified three deficiencies, none of which was significant. The deficiencies were related to lack of AED documentation, time-line and documentation

²² We reviewed the following cases with urgent or emergent events: 1-7, 9, 13-15, 18-21, and 23. Deficiencies occurred in cases 1, 4, 5, 7, 9, 13, 18, 19, and 23. Cases 1, 9, and 18 had significant deficiencies.

²³ Patients required CPR in cases 3-7. Deficiencies occurred in cases 4, 5, and 7.

discrepancies, and Narcan administration.²⁴ However, these deficiencies did not affect overall patient care.

Provider Performance

Providers generally performed well in urgent, emergent situations, and after-hours care. They usually made accurate diagnoses and completed documentation. However, we identified seven deficiencies related to emergency care.²⁵ The following are examples of significant deficiencies, all of which occurred in case 9.

- The provider documented the patient's blood pressure was low and heart rate was elevated within the setting of an elevated INR.²⁶ These findings could have suggested blood loss. In addition, the patient was receiving a medication (carvedilol) that lowers the blood pressure and heart rate. The provider should have considered adjusting the carvedilol or expediting the work-up for blood loss.
- The provider urgently evaluated the patient for symptomatic low blood pressure. The patient was of advanced age and had a recent elevated coagulation test result, but had been discharged back to housing after receiving intravenous fluids. The provider attributed the low blood pressure reading to an irregular heart rhythm, but did not consider blood loss as a cause for the patient's symptoms. In addition, the patient's blood pressure medication was continued at a higher dosage, which placed the patient at risk for further episodes of low blood pressure.
- The provider saw the patient for repeated episodes of low blood pressure, but did not adjust the blood pressure medication.

Nursing Performance

First medical responders and TTA nurses mostly performed good assessments, intervened, and notified the providers as required. Of the 20 deficiencies, six related to nursing performance.²⁷ The following are examples of significant deficiencies:

- In case 1, the patient with a history of stroke, hypertension, and diabetes had stroke-like symptoms, but the records indicated a 53-minute delay in calling 9-1-1. In addition, the nurse did not check the patient's blood-sugar level by performing a point-of-care glucose test. Point-of-care glucose testing is an accepted standard of care for patients who present with stroke-like symptoms.

²⁴ The lack of AED documentation included times of defibrillation and response to defibrillation.

²⁵ Deficiencies occurred in cases 9, 13, and 23. Case 9 had significant deficiencies.

²⁶ The INR is a laboratory test to measure the body's blood clotting mechanism. This test is used to monitor the effectiveness of blood thinning medications such as warfarin.

²⁷ Nursing performance deficiencies occurred in cases 1, 4, 5, 18, and 19.

- In case 18, a medical emergency was called for a patient who complained of chest pain, a rapid heart rate, and palpitations. Records indicated the nurse placed the AED on the patient 19 minutes after the notification, instead of immediately. A fast heart rate can progress rapidly and become life threatening without immediate intervention.

During our on-site visit, VSP agreed with these deficiencies and provided training to staff.

Nursing Documentation

First medical responders and TTA nurses mostly performed adequate documentation. We did not identify any significant documentation deficiencies.²⁸ The following are examples of deficiencies identified: (1) no order was documented for oxygen administration and (2) documentation did not identify the provider arrival time in the TTA, the time of defibrillation, or the patient's response to defibrillation.

Emergency Medical Response Review Committee

EMRRC met monthly, usually identified deficiencies, and provided staff training. Our clinicians reviewed 10 emergency events.²⁹ Examples of deficiencies not identified during the EMRRC or supervisor review include the following types: delay in applying the AED, lack of provider documentation for a patient sent to the hospital, and lack of chief nurse executive (CNE) and chief medical executive (CME) review of events.³⁰

Similarly, compliance testing revealed incomplete checklists, missing entries, untimely review of incidents, and missing clinical review by the supervising registered nurse II (SRN II), CME, or CNE (MIT 15.003, 50.0%). This is an opportunity for improvement.

Clinician On-Site Inspection

During our on-site visit to the TTA, we interviewed the nursing staff. They reported the TTA has two beds and is staffed with two RNs on each watch except on Mondays. On first watch, the TTA was staffed with three RNs. On weekends, the TTA was assigned a third RN on second watch. This RN collected the sick calls, triaged them, and evaluated patients with urgent complaints. The TTA had a provider who covered the TTA and the OHU, Monday through Friday. On-call providers covered after-hour periods and on holidays. The staff expressed nursing morale was low due to the prevailing short-staffing situation. Nursing staff

²⁸ Documentation deficiencies occurred in cases 1, 4, 18, and 19.

²⁹ We reviewed emergency events in cases 1, 3–7, 13, and 18–20. We identified deficiencies in cases 1, 4, 13, 18, and 19.

³⁰ The EMRRC or supervisors did not identify deficiencies for emergency events in cases 1, 4, 13, 18, and 19.

reported their supervisor was available, made rounds daily on second watch, and communicated information with the TTA staff via email.

The staff reported they did not have any Issues with supplies or pharmacy and found custody staff to be helpful. They maintained a well-supplied Omnicell (automated drug delivery system) with medications. The TTA had three emergency vehicles, one of which was out for repair.

Recommendations

- Medical and nursing leadership should ensure the EMRRC thoroughly audits emergency events, identifies all deficiencies, and ensures all required reviewers complete the clinical reviews.

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.

Results Overview

In this indicator, compliance testing and case review analysis had mixed results. Compliance determined VSP provided **proficient** health information management while case review resulted with an **inadequate** rating. Compliance found staff performed excellently in retrieving and scanning hospital and specialty records timely. However, staff also frequently mislabeled scanned records. Case review found hospital records were not always properly forwarded to the provider for review and the provider did not always endorse laboratory results timely. After careful consideration, both case review and compliance testing came to an agreement on rating this indicator **adequate**.

Overall
Rating
Adequate
Case Review
Rating
Inadequate
Compliance
Score
Proficient
(87.0%)

Case Review and Compliance Results

We reviewed 811 events and found 103 deficiencies related to health information management, 14 of which were significant.³¹

Hospital Discharge Reports

VSP staff timely retrieved hospital discharge records, scanned them into the EHRS, and reviewed them within the required time frames (MIT 4.003, 100%). Our clinicians reviewed 10 off-site emergency department and hospital visits and identified four deficiencies.³² The following are examples of significant deficiencies:

- In case 13, the provider endorsed the emergency room report 36 days after it was available in the EHRS.
- In case 18, health information management (HIM) staff scanned hospital documentation into the EHRS but did not forward the documentation to the provider for review or endorsement.

³¹ Deficiencies occurred in cases 1, 2, 6–6, 18–23, and 43–45. Cases 1, 8, 10, 13, 14, 16, 18, and 21 had significant deficiencies.

³² Deficiencies occurred in cases 13, 14, 18, and 21. Cases 13, 18, and 21 had significant deficiencies.

- In case 21, the HIM staff scanned the patient's emergency department records into the EHRS but did not send the report to the provider for review.

Specialty Reports

VSP did not consistently perform well in managing specialty reports. Compliance testing showed excellent retrieval of specialty reports (MIT 4.002, 93.6%), but fair to poor performance in provider endorsement of high-priority (MIT 14.002, 71.4%), medium-priority (MIT 14.005, 46.7%), and routine-priority (MIT 14.008, 71.4%) specialty reports.

Our clinicians reviewed 60 specialty reports and identified 12 deficiencies.³³ Six deficiencies were due to the providers endorsing the specialty reports outside policy time frames, three were due to delayed or mislabeled scans, and three reports were not properly forwarded to the provider for review. The following are examples of two significant deficiencies:

- In case 10, HIM staff scanned an echocardiogram report into the EHRS; however, HIM staff did not forward the report to the provider for review.
- In case 14, HIM staff scanned a nephrology consultation report into the EHRS; however, HIM staff did not forward the report to the provider for review.

We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

VSP had a mixed performance with managing diagnostic reports. Compliance testing showed a pattern of the late endorsement of STAT results (MIT 2.008, 40.0%). The providers also performed poorly with timely communicating pathology results to patients (MIT 2.012, zero), but reviewed the pathology reports mostly on time (MIT 2.011, 77.8%). Case reviewers identified 68 deficiencies related to incomplete (56) or missing (12) patient result letters, which, taken together, accounted for most of the diagnostic health information management deficiencies.³⁴ OIG clinicians also identified a minor pattern of significant deficiencies related to late provider endorsement of diagnostic results.³⁵ Please refer to the **Diagnostic Services** indicator for a further detailed discussion.

³³ Specialty health information management deficiencies occurred in cases 9, 10, 13–15, 18, 22, 23, and 44. Significant deficiencies occurred in cases 10 and 14.

³⁴ Deficiencies occurred in cases 1, 2, 6, 8–12, 14–16, 19, 20, and 43–45. No significant deficiencies occurred. Cases 1, 2, 6, 8–12, 14–16, 19, 20, 44, and 45 had deficiencies related to incomplete patient notification letters. Cases 1, 8, 9, and 43 had deficiencies related to missing patient notification letters.

³⁵ Deficiencies occurred in cases 1, 7–10, 13, 16, and 44. Seven significant deficiencies were identified in cases 1, 8, 10, and 16.

Urgent and Emergent Records

OIG clinicians reviewed 25 emergency care events and found nurses and providers recorded these events well. The providers also recorded their emergency care sufficiently, including off-site telephone encounters and no deficiencies were identified. The **Emergency Services** indicator provides additional details.

Scanning Performance

VSP had a mixed performance with the scanning process. While compliance testing found the institution occasionally properly labeled, scanned, and filed documents (MIT 4.004, 41.7%), the case reviewers identified only four deficiencies. None of these deficiencies was considered significant.³⁶

Clinician On-Site Inspection

We discussed health information management (HIM) processes with the health records technician (HRT) supervisor, who described the process of retrieving off-site reports. The HRT supervisor acknowledged some difficulty in obtaining reports from one community hospital. However, the HIM staff was able to establish a contact for medical records procurement the week before the OIG's on-site visit. Concerning specialty reports, the HRT supervisor reported the specialty department had an office technician (OT), who tracked specialty appointments and would try to obtain the report for the institution.

We discussed the process of ensuring timely provider review of reports and results with the HRT supervisor during the HIM meeting. We also discussed the process with the senior laboratory assistant and the correctional health services administrator during the diagnostic services meeting. The HRT supervisor reported HIM staff ran a provider deficiency report weekly and emailed the providers, a process that had been in place for approximately six years. The HRT supervisor noted the medical leadership had recently asked the HIM staff to run the report twice a week. Even so, we identified multiple deficiencies with providers' nonendorsements as described above.

The HRT supervisor reported HIM staffing was down. HIM was staffed for four HRTs and two and a half office assistants (OAs), but presently has three HRTs and one OA.

OIG clinicians discussed patient notification letters with providers and medical assistants. Medical assistants usually printed out the letters and prepared them for patient distribution. They reported most patients did not pick up the letters and often requested the results to be emailed to them instead.

³⁶ Deficiencies were identified in cases 2, 7, and 15.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	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) *	29	2	14	93.6%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	20	0	1	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	10	14	0	41.7%
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) *	21	0	0	100%
Overall percentage (MIT 4): 87.0%				

* 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.

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	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) *	4	6	0	40.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	7	2	1	77.8%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	8	2	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) *	10	4	1	71.4%
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) *	7	8	0	46.7%
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) *	10	4	1	71.4%

* 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.

Recommendations

- Medical leadership should identify challenges in scanning, labeling, and including medical records in the correct patient's file, and implement remedial measures as appropriate.
- The department should develop an electronic hard stop to not allow staff to complete a report scanning task until the report has been forwarded to the provider for review or endorsement.

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. Our case review clinicians do not rate this indicator.

Overall
Rating
Inadequate

Case Review
Rating
(N/A)

Compliance
Score
**Inadequate
(43.0%)**

Results Overview

In this cycle, VSP performed poorly in this indicator. Medical supplies storage areas in and outside of the clinics either contained expired medical supplies or medical supplies were directly stored on the floor. Emergency medical response bag (EMRB) logs were missing staff verification, inventory was not performed, or the bags were storing expired medical supplies. Several clinics did not meet the requirements for essential core medical equipment and supplies. Finally, staff did not regularly sanitize their hands before and 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. Health care and custody staff reported existing waiting areas had enough seating capacity, ample protection from inclement weather, and an operational misting system for use during extreme heat conditions (see Photo 1).

Indoor Waiting Areas

We inspected indoor waiting areas. Health care and custody staff reported existing waiting areas had sufficient seating capacity (see Photo 2, next page). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.



Photo 1. Shaded outdoor waiting area with mist cooling system (photographed on 1-20-23).



Photo 2. Indoor waiting area (photographed on 1-17-23).

Clinic Environment

All clinic environments were excellently conducive to medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 100%).

Of the eight clinics we observed, three contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 37.5%). The remaining five clinics had one or more of the following deficiencies: staff reported, although they could provide service to patients simultaneously and use privacy curtains, the examination room gurneys were too close to each other, which prevented auditory privacy during clinical examination; physical therapy equipment had a torn vinyl cover; examination rooms contained unidentified or inaccurately labeled examination room supplies; the examination room was unorganized or cluttered (see Photo 3, next page); examination room cabinets and desk were not free of trash (a food wrapper, a drink can, and unsanitized medical equipment); and an examination room had unsecured confidential medical records (see Photo 4, next page).



Photo 3. Cluttered examination room (photographed on 1-18-23).

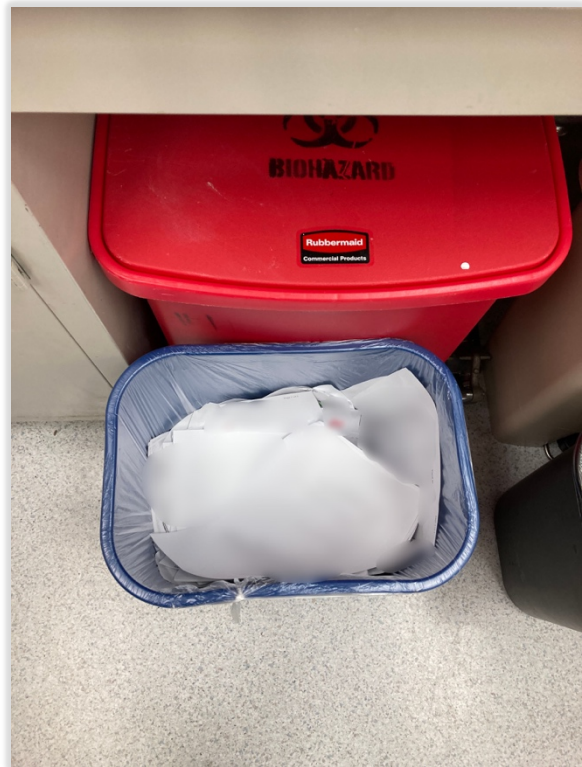


Photo 4. Unsecured confidential medical records (photographed on 1-18-23).

In addition to the above findings, our compliance inspectors observed the following notable findings in the clinic during their on-site inspection:

- The OHU clinic's medication cart was in disrepair (see Photo 5). Staff reported the cart had been damaged for several months. OHU staff had neither reported the issue nor filed a work order to replace or repair the broken medication cart.



Photo 5. OHU medication cart found in disrepair (photographed on 1-19-23).



Photo 6. Expired medical supplies dated December 2022 (photographed on 1-19-23).

Clinic Supplies

None of the nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, zero). We found one or more of the following deficiencies in nine clinics: medical supplies that were expired, unidentified, or disorganized (see Photo 6 and Photo 7); cleaning materials stored with medical supplies; staff members' personal items and food stored with medical supplies (see Photo 8, next page); bulk-food items stored long-term in the supply storage room location; and compromised sterile medical supply packaging.

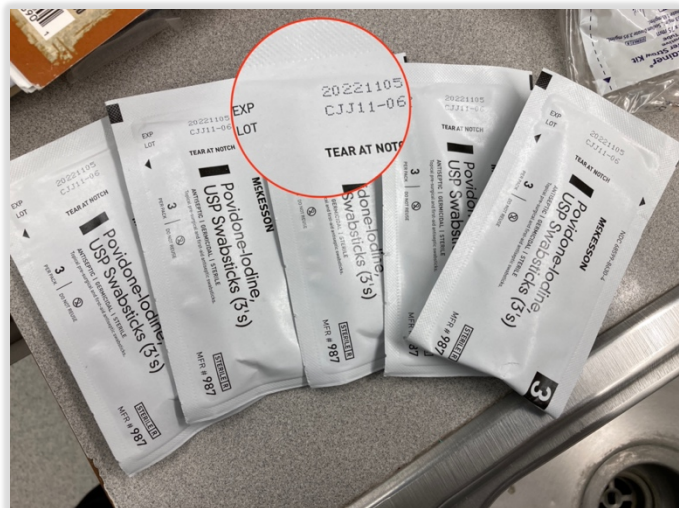


Photo 7. Expired medical supplies dated November 2022 (photographed on 1-19-23).

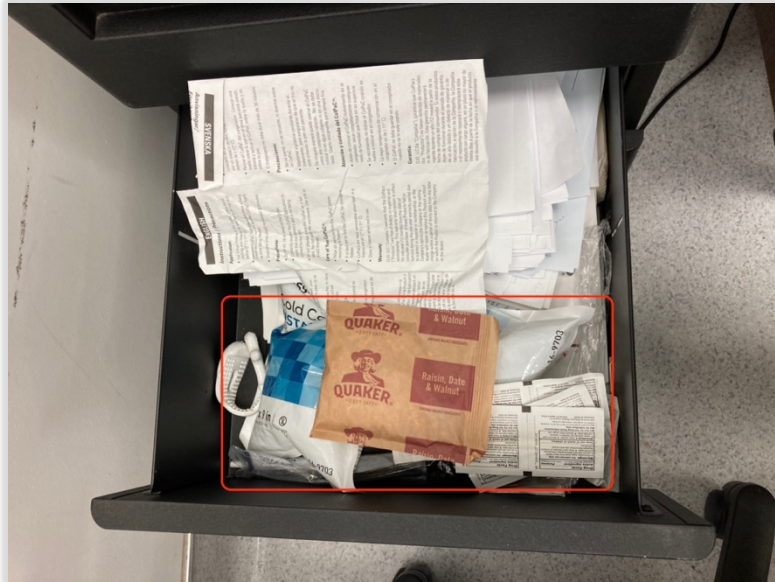


Photo 8. Staff's personal food item stored with medical supplies (photographed on 1-18-23).

Only two of the nine clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, 22.2%). The remaining seven clinics lacked medical supplies or had nonfunctional equipment. The missing items included an oto-ophthalmoscope, a biohazard receptacle bin or bag, a nebulizer, and lubricating jelly. The staff had not properly calibrated an oto-ophthalmoscope, vital signs machine, an overhead light, a weight scale, and a nebulizer. We found several nonfunctional oto-ophthalmoscopes. VSP staff either did not always document daily performance checks of the automated external defibrillator (AED) or did not complete the defibrillator performance test log documentations within the past 30 days. Moreover, daily glucometer quality control logs in several clinics were either inaccurate or incomplete (see Photo 9).

In addition to the above findings, our compliance inspectors observed the following notable findings in several clinics during their on-site inspection:

- Staff did not document having taken any action when the glucometer quality control results were beyond the range of what is accepted (see Photo 9, and Photo 10, next page).

DATE	TIME	GLUCOMETER SERIAL NUMBER	TEST STRIP LOT#	NORMAL CONTROL LOT#	HIGH CONTROL LOT #	QUALITY CONTROL TEST RESULTS	NURSING STAFF INITIALS
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							

VALUES (BOTTLES # 1&2)

LEVEL 1 NORMAL: 87-108

LEVEL 2 HIGH: 213-244

VALUES (BOTTLES # 1&2)

LEVEL 1 NORMAL: _____ MG/DL

LEVEL 2 HIGH: _____ MG/DL

RANGE LOCATED ON TEST STRIP CONTROL SOLUTION BOTTLES

ONLY IF A NEW SET OF CONTROL SOLUTION BOTTLES ARE USED**

Photo 9. Inaccurate glucometer daily quality control log and out-of-range results without action taken by staff (photographed on 1-20-23).

VSP revised 02/2020

GLUCOMETER QUALITY CONTROL RECORD

*MONITOR MUST BE CALIBRATED EVERY 24 HOURS. READINGS OUTSIDE THE PARAMETERS MUST BE REPORTED TO THE SRI IN ON DUTY.

DATE	Time	Glucometer Serial Number	Test Strip Lot #	Normal Control Lot #	High Control Lot #	Quality Control Test Results	Nursing Staff Initials
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							

VALUES (Bottle #1)

Level 1 Normal: 7 - 10.8 mg/dl

Level 2 High: 24.5 - 31.8 mg/dl

Range located on Test Strip Bottle

VALUES (New Lot Bottle)

Level 1 Normal: mg/dl

Level 2 High: mg/dl

Should be required to use a new box of Test Strips, use this section to add new Range Values.

Photo 10. Staff did not take proper action when glucometer quality control results were out of range (photographed on 1-18-23).

We examined EMRBs to determine whether they contained all essential items. We checked whether 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: staff failed to ensure the EMRBs' compartments were sealed and intact; staff had not inventoried EMRBs when the seal tags were replaced; and medical supplies stored in EMRBs were expired or the original packaging was compromised (see Photo 11). The TTA staff did not properly perform an inventory of the treatment cart, and the treatment cart daily check sheet indicated the cart had missing items that were not replaced as per CCHCS policy. We also found compromised medical supplies stored in the treatment cart.

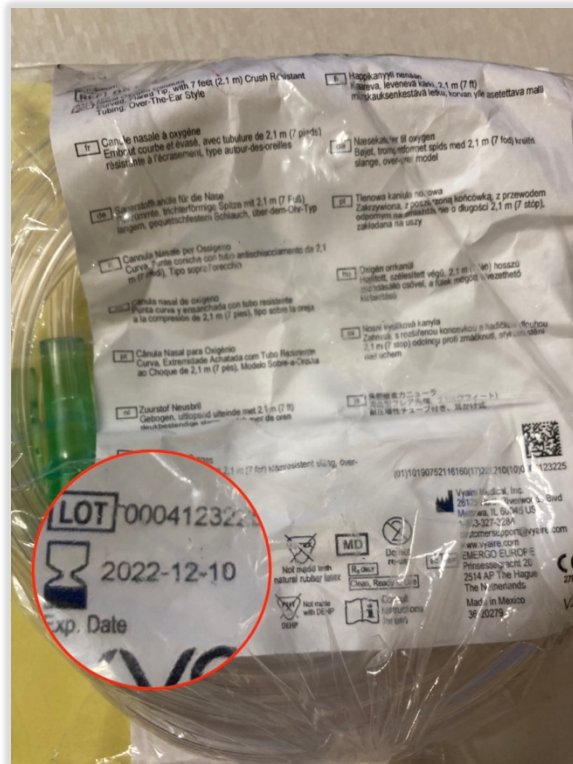


Photo 11. Expired EMRB supply dated December 2022 (photographed on 1-19-23).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics contained adequately stored medical supplies (MIT 5.106, zero). The warehouse manager did not maintain a temperature log for medical supplies with manufacturer temperature guidelines stored in the Conex box. In addition, we found medical supplies stored directly on the floor (see Photo 12). According to the CEO, the institution did not have any concerns about the medical supplies process. Health care managers and medical warehouse managers expressed no concerns about the medical supply chain or their communication process.



Photo 12. Medical supplies stored directly on the floor (photographed on 1-18-23).

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 both of the following deficiencies: cleaning logs were not maintained, and biohazardous waste was not emptied after each clinic day.

Staff in five of seven applicable clinics properly sterilized or disinfected medical equipment (MIT 5.102, 71.4%). In two clinics, examination table disposable paper was not removed and replaced in between patient encounters.

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, patient restrooms lacked disposable hand towels. In another clinic, the examination room lacked disposable hand towels and had a nonfunctional hand dryer.

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

Health care staff in eight of nine clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 88.9%). In one clinic, nursing staff did not describe the appropriate disinfection process of medical equipment after exposure to biohazardous waste.

Physical Infrastructure

We gathered information to determine whether the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely, adequate health care. At the time of our inspection, the institution had two infrastructure projects underway, which management staff felt would improve the delivery of care at VSP. These are detailed below:

- Project SP 3.1: Expansion of Clinic B, which began December 2013. The project had been delayed due to pending approval from the State Fire Marshall and, at the time of inspection, project completion had been expected by January 2023.
- Project SP 3.2: Renovation of Clinic B, which began September 2020. This project had also been delayed due to pending approval from the State Fire Marshall and, at the time of inspection, project completion had been expected by February 2023.

Despite the delay of both projects SP 3.1 and SP 3.2 described above, when we interviewed health care managers, they did not have concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care (MIT 5.999).

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	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)	5	2	2	71.4%
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)	8	1	0	88.9%
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)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	0	9	0	0
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	2	7	0	22.2%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	3	5	1	37.5%
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): 43.0%				

* 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

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Executive leadership should consider performing random spot checks to ensure medical supply storage areas, which were located outside the clinics, store medical supplies adequately.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure these bags and carts are regularly inventoried and sealed.

Transfers

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 care 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 in 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.

Overall
Rating
Inadequate

Case Review
Rating
Adequate

Compliance
Score
**Inadequate
(56.5%)**

Results Overview

VSP's performance was mixed for this cycle. On one hand, for patients arriving at VSP, nurses continued this cycle to perform incomplete initial health screenings; newly arrived patients had lapses with medication continuity; and specialty service appointments did not occur within required time frames. On the other hand, for patients who returned from an off-site hospital, nurses performed satisfactory assessments. However, continuity of hospital recommended medications was problematic. Taking all factors into account, we rated this indicator *inadequate*.

Case Review and Compliance Testing Results

We reviewed 33 events in 17 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 17 deficiencies, four of which were significant.³⁷

Transfers In

OIG clinicians reviewed 17 events in five cases in which patients transferred into the facility from other institutions. We identified six deficiencies, none of which was significant.³⁸

Our clinicians found R&R nurses generally completed the nursing screening thoroughly. However, in one case, we identified deficiencies wherein a nurse did

³⁷ We reviewed cases 1, 7, 9, 13, 14, 18–21, 23–29, and 45. Deficiencies occurred in cases 7, 13, 14, 18, 21, 24, 26, and 28. Cases 13, 18, and 21 had significant deficiencies.

³⁸ We reviewed cases 7, 21, and 24–26 for patients who arrived at VSP. Deficiencies occurred in cases 7, 21, 24, and 26.

not weigh the patient on multiple occasions when he arrived at VSP.³⁹ In two other cases, the nurse did not reassess the patients for elevated heart rates and blood pressure levels.⁴⁰

R&R nurses performed well for MIT 6.002, scoring 86.4 percent. Nurses frequently completed the assessment and disposition section of the initial health screening form.

Compliance testing identified R&R nurses completed the initial health screening within the required time frame. However, the screening was not completed thoroughly (MIT 6.001, 20.0%). Nurses frequently did not document an explanation when patients answered “yes” to the question asking whether they had ever been treated for mental illness. Our case reviewers identified one deficiency in which the nurse did not request additional information when the patient answered “yes” for significant dental problems and had recently received bad news.⁴¹

Both case reviewers and compliance testing found patients who arrived at VSP were seen by the provider within the required time frame (MIT 1.002, 76.0%). Our case reviewers did not identify any deficiencies for timely provider access.

For medication continuity, case review and compliance reached different results. Our case reviewers did not identify any problems with medication continuity for patients who arrived at VSP. In contrast, compliance testing resulted in a low score of 69.6 percent (MIT 6.003). Patients who were temporarily housed at VSP intermittently received their medications without interruption (MIT 7.006, 70.0%). For those patients who transferred from one housing unit to another within the facility, VSP performed very well, with patients frequently receiving their medication without disruption (MIT 7.005, 88.0%).

Specialty service appointments for patients who arrived at VSP sometimes occurred within required time frames (MIT 14.010, 50.0%), but some appointments were seven to 67 days late.

Transfers Out

VSP’s transfer-out process had mixed results for compliance and case review. We reviewed 15 events in five cases and identified three deficiencies, none of which was significant.⁴²

The three case review deficiencies related to medication administration and nursing documentation. Our clinicians found one deficiency wherein the patient did not receive his medications prior to transferring out of VSP.⁴³ Compliance testing found one of two patients tested who transferred out of the institution

³⁹ On three occasions, for case 7, the nurse did not weigh the patient.

⁴⁰ The R&R nurse did not reassess the patients elevated blood pressure or heart rate in cases 7 and 24.

⁴¹ In case 26, the nurse did not inquire for additional information.

⁴² We reviewed transfer out events in cases 7, 27–29, and 45. Deficiencies occurred in cases 7 and 28.

⁴³ In case 7 the patient did not receive his medications prior to transferring out of VSP. During our on-site visit, VSP agreed with our findings.

was not sent with his medications and required documents (MIT 6.101, 50.0%). Additionally, one of the patients sampled had one medication with an expired pharmacy label.

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. They require more care and place a strain on the institution's resources. In addition, because these patients have complex medical issues, successful health information transfers are necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

For hospital returns, VSP's performance resulted in different findings for case review and compliance testing. Our clinicians reviewed 10 events in 10 cases in which patients had returned from an off-site hospitalization or emergency room visit. We identified seven deficiencies, four of which were significant.⁴⁴

Nurses completed adequate assessments when patients returned from the hospital or emergency room. Our case reviewers did not identify any significant deficiencies related to nursing performance.⁴⁵

VSP performed poorly for continuity of hospital recommended medications (MIT 7.003, 23.8%). Please refer to the **Medication Management** indicator for details. OIG case reviewers identified one deficiency in which the patient did not receive one dose of his chronic care medications.⁴⁶

Compliance testing showed excellent performance for provider follow-ups (MIT 1.007, 100%), availability, and quality of discharge summaries (MIT 4.003 and MIT 4.005, 100%). On the other hand, case reviewers cited four HIM deficiencies, three of which were significant. Please refer to the **Health Information Management** indicator for further discussion on cases 13, 18, and 21.

Although compliance testing was excellent for provider follow-ups, our clinicians identified the following significant provider deficiency:

- In case 18, the provider saw the patient to follow-up on the patient's hospitalization for dysrhythmia, cardiac arrest, and automatic implantable cardioverter defibrillator (AICD) placement.⁴⁷ Per the hospital discharge summary, a sleep study was recommended to further evaluate the patient for the presence of obstructive sleep apnea (OSA). Untreated OSA has the potential for causing dysrhythmias. However, the provider did not order the sleep study,

⁴⁴ Patients returned from a hospitalization or emergency room visit in cases 1, 9, 13, 14, 18–21, 23, and 45. Deficiencies occurred in cases 13, 14, 18, and 21. Cases 13, 18, and 21 had significant deficiencies.

⁴⁵ Case 18 had one nursing deficiency in which the nurse did not weigh the patient upon the patient's return from a hospitalization.

⁴⁶ In case 14, the patient did not receive an evening dose of his medications, Apixaban, which prevents blood clots, and Aripiprazole, a psychiatric medication.

⁴⁷ Dysrhythmia is a medical condition with an abnormal heart rhythm.

thus increasing the risk for recurrence and potentially fatal dysrhythmias. In addition, the provider did not address the patient's obesity as recommended by the hospitalist, which is a risk factor for OSA.

Clinician On-Site Inspection

The R&R nurse we interviewed was familiar with the transfer process and reported no issues with supplies, equipment, or the pharmacy. We were informed the administrative staff are receptive, and their relationship with custody staff is good. Second and third watches have one RN assigned to them. The TTA nurse performs transfer duties on first watch as needed. On average, six patients arrive at VSP and three transfer out of VSP daily. The R&R nurse informed us the institution rarely has issues with transfers. On the occasions when medications or durable medical equipment are missing, items are replaced immediately.

We also interviewed the SRN covering for the R&R SRN. She informed us the administration has an open-door policy, nursing has a good relationship with custody staff, and no supply issues exist.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	5	20	0	20.0%
For endorsed patients received from another CDCR institution: 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)	19	3	3	86.4%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	16	7	2	69.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	1	1	0	50.0%
Overall percentage (MIT 6): 56.5%				

* 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) *	19	6	0	76.0%
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) *	21	0	0	100%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	20	0	1	100%
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) *	21	0	0	100%
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) *	5	16	0	23.8%
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) *	7	3	0	70.0%
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) *	10	10	0	50.0%

* 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 ensure R&R nurses confirm all patients transferring out of the institution have required medications, transfer documents, and assigned DME.
- Medical, nursing, and pharmacy leadership should ensure newly arrived patients and patients returning from a hospitalization receive recommended medications to ensure medication continuity.
- Nursing leadership should educate R&R nurses to thoroughly complete the initial health screening, including answering all questions and documenting an explanation for each “yes” answer, documenting a complete vital signs check as part of the patient’s initial health screening assessment, and completing the initial health screening form prior to the patient being placed in housing.

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
(57.0%)**

Results Overview

As in the previous cycle, VSP continued to perform poorly with medication management. While case review analysis found adequate performance, compliance testing indicated significantly inadequate performance. Compliance testing overall showed low scores for most areas including medications for new prescriptions, chronic care, hospital discharge, specialized medical housing (SMH), new arrivals at VSP, and en route layover patients. However, VSP's nurses generally administered medications as ordered, including TB medications. After factoring in all aspects of medication management, we rated this indicator **inadequate**.

Case Review and Compliance Testing Results

We reviewed 140 events in 28 cases related to medications and found 24 medication deficiencies, four of which were significant.⁴⁸

New Medication Prescriptions

For new medication availability, Compliance testing found the institution's performance needed improvement because new medications were not available within the required time frame (MIT 7.002, 52%). Specifically, compliance results showed 12 out of 25 patients sampled received medications one to four days late. Examples of medications received late included those for cholesterol, diabetes, and urinary concerns.

Our clinicians found four deficiencies indicating a pattern of late administration of newly ordered medications.⁴⁹ Three examples follow:

- In case 15, the patient complained of severe ear pain. The provider ordered ibuprofen; however, the patient received the new medication one day late.

⁴⁸ We reviewed cases 1, 2, 6–24, 26–29, and 43–45. Deficiencies occurred in cases 1, 2, 6, 7, 11, 14, 15, and 20–22. Cases 1 and 22 had significant deficiencies.

⁴⁹ Patients received newly ordered medications late in cases 11, 15, 21, and 22.

- In case 21, the provider discontinued the diltiazem prescription and ordered a new cardiac antiarrhythmic medication, Flecainide, for the patient to start taking the same day.⁵⁰ However, the patient did not receive the medication until the following morning.
- In case 22, the provider ordered the new keep on person (KOP) medication, polycarbophil.⁵¹ However, the patient received the medication ten days late.

Chronic Medication Continuity

During this review period, VSP performed poorly with chronic medication continuity. Compliance testing showed VSP had difficulty ensuring medication continuity for patients with chronic conditions. Patients did not receive their chronic care medications timely (MIT 7.001, zero). This zero score resulted from the pharmacy not filling and dispensing KOP medications timely. Our clinicians also found cases in which chronic medications were not received timely or at all.⁵² The following are examples of significant deficiencies:

- In case 1, during the month of June 2022, the patient did not receive his KOP chronic care medications for blood pressure (Amlodipine and Losartan) and aspirin. The medications were ordered as automatic refills; however, the medication administration record (MAR) documentation stated, “not done, task duplication” for all three medications.
- Also in case 1, during the month of July 2022, the patient did not receive his chronic care KOP medications for aspirin and blood pressure (hydrochlorothiazide) as ordered. Both medications were ordered as automatic refill types.
- In case 22, during the month of July 2022, the patient received his chronic care KOP medications for blood pressure, cholesterol, and blood thinning six to eight days late.

Hospital Discharge Medications

Overall, VSP performed poorly in patients receiving their discharge medications upon return from an off-site hospitalization or emergency room visit (MIT 7.003, 23.8%). Most medications were one to three days late with one exception in which the medication was 60 days late. Our clinicians reviewed 10 hospitalization

⁵⁰ Flecainide is a medication which is used to treat abnormal heart rhythms.

⁵¹ KOP means “keep on person” and refers to medications in which a patient can keep and self-administer according to the directions provided. Polycarbophil is a bulk-forming laxative that increases the amount of water in a patient’s stools to help make the stools softer and easier to pass.

⁵² Patients did not receive chronic care medications timely or did not received medications in cases 1, 2, 6, 7, 11, 14, 20, and 22 with multiple occurrences in most of these cases.

events in 10 cases and found VSP's performance was acceptable.⁵³ Please refer to the **Transfers** indicator for additional details.

Specialized Medical Housing Medications

Case review and compliance testing had mixed results. Compliance testing indicated the institution needs improvement (MIT 13.003, 55.6%). Although patients received their medications as ordered, the low score was due to the pharmacy not filling and dispensing the medications timely. In contrast, case reviewers did not identify any medication deficiencies.

Transfer Medications

Case review showed better results for transfer medications compared with the findings from compliance testing.⁵⁴ Our compliance testing indicated when patients arrived at VSP, they did not always receive their medications without interruption. However, when patients transferred among housing units within the facility, they frequently received medications without disruption. Additional information is discussed in the **Transfers** indicator.

Medication Administration

Our clinicians found nurses generally administered medications timely as ordered.⁵⁵ VSP performed very well in administering TB medications (MIT 9.001, 88.9%). However, nurses sporadically performed weekly monitoring of patients who were prescribed TB medications (MIT 9.002, 33.3%). Side effects from TB medications can be harmful to the liver; therefore, timely patient monitoring is important.

Clinician On-Site Inspection

Medication LVNs attend daily clinic huddles via teleconference if they are unable to attend in person, and they communicate patient medication issues with the providers via email.

We interviewed several medication nurses, and they were familiar with medication-related processes such as KOP medications, patient refusals, and the transfer process. The LVN staff reported, for KOP medications, ducats are sent to patients to pick up their medications via the institution ducat system as opposed to the previous process of handwritten ducats.⁵⁶ The new process allows ducats to be tracked and ensures patient notification.

⁵³ Case 14 had a deficiency related to hospitalization medication where the patient did not receive an evening dose of an anticoagulant medication (Apixaban).

⁵⁴ Transfer cases 7 and 21 had two deficiencies related to medication management. One deficiency was related to missing documentation on the medication administration record and the other the patient did not receive his morning dose of psychiatric medications prior to transferring out of VSP.

⁵⁵ Deficiencies related to medication administration occurred in cases 11 and 20.

⁵⁶ A ducat is a pass that allows patients to move in an institution.

The Omnicell was primarily used to store narcotics. The medication LVNs informed us they mostly received medications timely from the pharmacy. At times, they experienced issues with scanning medications and needed to create entries manually. Overall, nurses reported their communication with the pharmacy was good, and they did not have any equipment or supply issues.

Medication nurses also explained their role as emergency responders to us. They had the required equipment for responding to medical emergencies.

Medication nurses reported they believed nursing morale was fair, they could communicate concerns to their supervisors, and they had a good rapport with custody staff.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in eight of nine applicable clinics and medication line locations (MIT 7.101, 88.9%). In one location, narcotic medications were not properly securely stored as required by CCHCS policy.

VSP appropriately stored and secured nonnarcotic medications in two of 10 clinic and medication line locations (MIT 7.102, 20.0%). In eight locations, we observed one or more of the following deficiencies: the medication storage cabinet and cart was disorganized; the medication area lacked a clearly labeled designated area for nonrefrigerated or refrigerated medications identified for return to the pharmacy; nurses did not maintain unissued medication in its original labeled packaging; and medications were not properly securely stored as required by CCHCS policy.

Staff kept medications protected from physical, chemical, and temperature contamination in three of the 10 clinics and medication line locations (MIT 7.103, 30.0%). In seven locations, we found one or more of the following deficiencies in which staff did not do the following: consistently record the room and refrigerator temperatures; store oral and topical medications separately; or separate medications from disinfectants. In addition, the medication refrigerator was unsanitary.

Staff successfully stored valid and unexpired medications in six of the 10 applicable medication line locations (MIT 7.104, 60.0%). In four locations, we found one or more of the following deficiencies: medication nurses did not label multiple-use medication as required by CCHCS policy; medication was stored beyond the expiration date; and a medication was stored beyond the labeled use date.

Nurses exercised proper hand hygiene and contamination control protocols in one of six applicable locations (MIT 7.105, 16.7%). In five locations, some nurses neglected to wash or sanitize their hands before donning gloves, before each subsequent regloving, or to resanitize their hands and change gloves when gloves were compromised.

Staff in five of six applicable medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 83.3%). In one location, the medication nurses did not describe the process they followed when reconciling newly received medication and the MAR against the corresponding physician's order.

Staff in three of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to patients (MIT 7.107, 50.0%). In one location, medication nurses did not reliably observe patients while they swallowed direct observation therapy medications. In another location, we observed a medication nurse did not follow the CCHCS care guide when administering Suboxone medication. In the remaining location, we observed some medication nurses did not properly disinfect the vial's port prior to withdrawing medication during insulin administration.

Pharmacy Protocols

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

The pharmacist-in-charge (PIC) did not adequately manage narcotic medications stored in VSP's pharmacy. The PIC incorrectly reviewed monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC and the pharmacist did not complete several medication area inspection checklists (CDCR Form 7477). These errors resulted in a very poor score for this test (MIT 7.111, zero).

We examined 21 medication error reports. The PIC timely or correctly processed 18 of these 21 reports (MIT 7.112, 85.7%). For three reports, we found one or more of the following deficiencies due to the PIC not appropriately documenting the following: the reason why the patient and provider were not notified of the error; where the error occurred within the pharmacy process; or the recommended changes to correct the errors or prevent them from occurring in the future. In addition, the PIC could provide no evidence the pharmacy follow-up review had been performed within the required time frame.

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 VSP, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in the restricted housing units to determine whether they had immediate access to their prescribed rescue medications. One of three applicable patients interviewed indicated they did not have access to their rescue medications. The patient verbalized the medication was taken away and placed in their property when transferred to the restrictive housing unit five days ago. The patient reported he notified medical staff the previous day,

requesting a replacement. We promptly notified the CEO of this concern, and health care management immediately reissued a replacement rescue inhaler to the patient (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) *	0	22	3	0
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	13	12	0	52.0%
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) *	5	16	0	23.8%
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) *	7	3	0	70.0%
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)	8	1	1	88.9%
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)	2	8	0	20.0%
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)	3	7	0	30.0%
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)	6	4	0	60.0%
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)	1	5	4	16.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	5	1	4	83.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	3	3	4	50.0%
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)	18	3	0	85.7%
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): 57.0%				

* 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.

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	16	7	2	69.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	1	1	0	50.0%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	8	1	0	88.9%
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) *	3	6	0	33.3%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003) *	5	4	0	55.6%

* 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 staff timely make available and administer medications to patients and staff document in EHRS 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 being at high risk for coccidioidomycosis (valley fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score. Our case review clinicians do not rate this indicator.

Overall
Rating
Inadequate

Case Review
Rating
(N/A)

Compliance
Score
**Inadequate
(72.8%)**

Results Overview

VSP had a mixed performance in preventive services. Staff performed well in administering TB medications, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. However, VSP rarely monitored patients taking prescribed TB medications and rarely offered required immunizations to chronic care patients. The OIG rated this indicator *inadequate*.

Compliance Testing Results

Table 16. Preventive Services

Compliance Questions	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	8	1	0	88.9%
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)	3	6	0	33.3%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
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)	25	0	0	100%
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)	2	12	11	14.3%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
Overall percentage (MIT 9): 72.8%				

* 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 consider developing and implementing measures to ensure nursing staff monitor patients who are receiving TB medications according to CCHCS guidelines.
- Medical leadership should analyze the challenges related to the untimely provision of preventative vaccines and implement remedial measures as warranted.

Nursing Performance

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), certified nursing assistants (CNAs), and medical assistants (MAs). Our clinicians evaluated nurses' performance in making timely and appropriate assessments and interventions. We also evaluated the institution's nurses' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance across 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.

Overall
Rating
Adequate
Case Review
Rating
Adequate
Compliance
Score
(N/A)

When summarizing overall nursing performance, our clinicians understand 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

VSP nurses provided good nursing care, which was similar to Cycle 6 findings. Compared with Cycle 6, VSP had fewer nursing performance deficiencies. Nurses frequently performed good assessments, intervened timely, and documented as required. However, we identified an opportunity for improvement in the outpatient clinic area: the nursing assessments could be more thorough. Our OIG clinicians rated this indicator *adequate*.

Case Review Results

We reviewed 179 nursing encounters in 44 cases. Of the 179 nursing encounters, 91 occurred in the outpatient setting. We identified 45 nursing performance deficiencies, two of which were significant.⁵⁷

Outpatient Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements. Overall, nurses completed thorough assessments and provided care by intervening timely and appropriately. However, completing thorough assessments is an opportunity for improvement for the outpatient clinic nurses. Our clinicians reviewed 47 sick call requests and identified 21

⁵⁷ We reviewed nursing encounters in cases 1–7, 9–11, and 13–45. Deficiencies occurred in cases 1, 2, 4, 5, 7, 13–16, 18, 19, 21, 23, 24, 26, 28, 34, 35, 38, 39, 41, 44, and 45. Cases 1 and 18 had significant deficiencies.

deficiencies, none of which was significant.⁵⁸ Clinic nurses frequently performed timely face-to-face triage. They generally provided interventions timely and performed good documentation.⁵⁹ However, we identified a pattern of deficiencies for incomplete assessments.⁶⁰ Examples include the following cases:

- In case 18, the patient submitted a sick call request reporting he was experiencing short-term memory loss, a sharp pain in his buttocks that went down his leg, and waking every night feeling his heart quivering, a situation that was continually worsening.
 - The nurse did not further inquire about any of the patient's complaints. The patient reported he was compliant with his medications, but he had been experiencing recent short-term memory loss and heart quivering. The concern regarding the recent memory changes would have been related to the patient remembering to take his KOP heart medications. The nurse should have had the patient bring his medications to the clinic to check whether he had been taking the medications as ordered.
 - The nurse also should have asked the patient if he had experienced such symptoms as shortness of breath, dizziness, or chest pain with the episodes of his heart quivering.
 - Regarding the pain radiating from the buttocks down the leg, the nurse did not assess the patient's gait, inquire about recent injuries, or determine if the pain was on the right or the left side.
 - The nurse should have co-consulted with a provider or scheduled a provider follow-up regarding the patient's multiple complaints.
 - The nurse did not provide patient education for this encounter.
- In case 34, the patient submitted a sick call request reporting he was continuing to have chest and stomach pain every couple of days. He had stated, "I'm having them now." He also reported frequent urination.
 - The nurse triaged the sick call at 7:30 a.m. and evaluated the patient at 9:30 a.m., two hours later. The nurse should have contacted the building's custody staff and instructed them to

⁵⁸ We reviewed sick call request in cases 2, 11, 13–16, 18, 19, 21, 23, and 30–42. Deficiencies occurred in cases 2, 13–16, 18, 19, 21, 34, 35, 38, 39 and 41.

⁵⁹ Sick call intervention deficiencies occurred in cases 14, 18, and 34. Sick call documentation deficiencies occurred in case 15, 16, 21, and 38.

⁶⁰ Sick call nursing assessment deficiencies occurred in cases 2, 13, 14, 18, 19, 21, 24, 35, 38, and 39. Cases 2, 18, and 21 had multiple deficiencies.

call a medical emergency if the patient were experiencing chest and stomach pain.

- The nurse evaluated the patient in the clinic, but did not perform a thorough assessment. The nurse also did not assess the patient for bowel sounds, his last bowel movement, and his last meal.
- The patient had multiple complaints including chest pain, stomach pain, and urinary symptoms. The nurse should have co-consulted with a provider.

Outpatient 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. Although we identified a few documentation deficiencies, nurses mostly completed thorough and accurate documentation.

Wound Care

OIG clinicians reviewed two cases in which nursing staff provided wound care. We did not identify any deficiencies.⁶¹

Case Management

OIG clinicians reviewed three cases in which patients were evaluated by a care manager.⁶² We did not identify any deficiencies. The clinic RNs were the care managers. LVNs performed care coordinator duties that included distributing DME, performing screenings and immunizations, and obtaining orders for laboratory results.

Emergency Services

Overall, nurses provided good emergency medical care. We reviewed 25 urgent or emergent events and identified six deficiencies related to nursing performance, two of which were significant. Please refer to the **Emergency Services** indicator for further discussion.

Hospital Returns

We reviewed 10 events in which patients returned from off-site hospitals or emergency rooms. The nurses performed good nursing assessments, which we detailed further in the **Transfers** indicator.

⁶¹ We reviewed wound care in cases 23 and 43.

⁶² A care manager evaluated patients in cases 14, 17, and 21.

Transfers

Nursing performance for transfers was acceptable. Nurses completed timely assessments and initiated appointments within appropriate time frames. However, for patients arriving at VSP, the screening was not always complete. We reviewed nine cases involving transfer-in and transfer-out processes. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

SMH nursing performance was adequate. We reviewed three cases with a total of 51 OHU events, 20 of which were nursing events. Of the nine deficiencies identified, four were related to nursing performance. We did not identify any significant deficiencies. For further details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

Specialty services nursing care was adequate. We reviewed 17 nursing events in eight cases in which patients returned to the institution after specialty procedures or consultations. We identified two deficiencies, neither of which was significant. Nurses mostly performed good assessments, reviewed specialty reports, and communicated with providers as required. Please refer to the **Specialty Services** indicator for additional details.

Medication Management

Nursing medication management at VSP was acceptable. Our clinicians reviewed 140 events related to medication management and identified 24 deficiencies, four of which were significant. Nurses generally administered medications as ordered and timely. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

During our on-site inspection, we interviewed VSP nursing leadership and staff, and we visited outpatient clinics, medications rooms, the TTA, the R&R, and the OHU. The acting CNE had been in the position for two weeks.

Clinic nurses informed us they did not have any backlog RN or PCP appointments at the time of our visit. The number of patients seen daily by clinic RNs varied from clinic to clinic. One of the clinic RNs on average evaluated 15 to 20 patients daily. In addition to the scheduled patient appointments, the nurse lines had patients added to the line daily, which included walk-in patients.

Clinic nursing staff reported receiving supplies timely. One of the SRNs informed us that, a week before our visit, the facility had initiated a new supply process which entailed organizing the supply storage areas and ordering supplies electronically.

The SRN discussed recent process improvements. She informed us adding a third LVN to the medication line had reduced patient wait times and increased medication compliance. Another yard experienced a supply shortage for suboxone. To resolve this issue, the pharmacy had increased the number of bins with suboxone doses in the Omnicell. Additional improvement projects included clarifying institution policies on (1) circumstances when an RN should co-consult with a provider and (2) correctly entering orders. VSP had also implemented a project to identify causes of long provider appointment line wait times and solutions to reduce those waits.

We also interviewed nursing instructors, who shared they have all the tools and resources they needed to provide staff training except for a designated training space. Nursing instructors were accessible to nursing staff daily to answer questions. Some of these instructors' other duties included onboarding new staff, creating curriculums, collaborating with supervisors for one-on-one training, and participating in committees. At the time of our inspection, they were providing new staff orientation to 11 new staff members, which included RN, LVN, and MA staff.

Overall, the VSP nursing staff expressed nursing morale was fair, and they had good communication with their supervisors, the pharmacy, and custody staff.

Recommendations

- Nursing leadership should ensure thorough assessments are completed for all face-to-face encounters.

Provider Performance

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.

Overall
Rating
Inadequate

Case Review
Rating
Inadequate

Compliance
Score
(N/A)

Results Overview

VSP providers struggled with consistently delivering good care. The providers made accurate assessments and appropriate treatment plans at times, but the OIG physicians found opportunities for improvement in several important areas. VSP's providers repeatedly did not review their patients' medical records sufficiently, document their medical care, or address significant or abnormal test results timely. After careful consideration of all these factors, we rated this indicator *inadequate*.

Case Review Results

The OIG clinicians reviewed 113 medical provider encounters and identified 78 deficiencies related to provider performance, 22 of which were significant.⁶³ In addition, our clinicians examined the quality of care in 20 comprehensive case reviews. Of these 20 cases, we found 14 *adequate* and six *inadequate*.⁶⁴

Outpatient Assessment and Decision-Making

Providers generally made appropriate assessments and sound decisions for their patients. They mostly took good histories, formulated differential diagnoses, ordered appropriate tests, provided care with the correct diagnosis, and referred patients to proper specialists when needed. However, our clinicians identified 21 significant deficiencies related to poor assessments and decision-making.⁶⁵ These severe deficiencies were found only in the six inadequate cases. The deficiencies listed below illustrate poor decision-making:

- In case 6, the provider evaluated the patient to discuss adding an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication due to the patient's history of diabetes and hypertension. The provider documented the patient had an allergy to lisinopril, an ACEI, but did not document what the

⁶³ Deficiencies occurred in cases 1, 6, 8–14, 16, 17–21, 23, 31, 33, and 42–45. Cases 6, 8, 9, 13, 18, and 20 had significant deficiencies.

⁶⁴ Cases 6, 8, 9, 13, 18, and 20 were rated *inadequate*.

⁶⁵ Significant deficiencies in assessments and decision-making occurred in cases 6, 8, 9, 13, 18, and 20.

allergic reaction was. The provider ordered an ARB, but did not order the appropriate follow-up laboratory tests. Serum potassium and creatinine laboratory testing levels should be checked on patients taking ARB due to the risk of high potassium and acute kidney problems while taking this medication.

- In case 9, the nurse notified the provider of abnormal STAT complete blood count results; however, the provider did not intervene for the abnormal result.
- Also in case 9, the provider evaluated the patient for repeated episodes of low blood pressure, but did not adjust the dosage of the blood pressure medication.⁶⁶

Emergency Care

Providers usually managed patients in the TTA with urgent or emergent conditions appropriately. In addition, providers were available for consultation with TTA staff. We identified seven deficiencies related to emergency care,⁶⁷ which were discussed further in the **Emergency Services** indicator.

Specialized Medical Housing

Providers generally delivered good care in the OHU. We further discuss specialized medical housing provider performance in the **Specialized Medical Housing** indicator.

Specialty Services

Providers appropriately referred patients for specialty consultation when needed. When specialists made recommendations, providers usually followed the recommendations appropriately and reviewed specialty reports timely. We identified only one deficiency in case 14, which was not significant, related to the provider not ordering a specialty recommended laboratory test.

Outpatient Review of Records

Providers did not consistently review medical records carefully. We found deficiencies related to the provider not reviewing medication records and blood-sugar levels from finger-stick tests. We identified 10 deficiencies in cases related to poor or no review of medical records.⁶⁸ The following are examples of significant deficiencies:

- In case 9, the provider sent a patient notification letter stating test results were “Normal or No Change.” However, the chest X-ray

⁶⁶ The blood pressure medication, a beta-blocker, can lower the blood pressure and heart rate.

⁶⁷ Deficiencies occurred in cases 9, 13, and 23. Case 9 had significant deficiencies.

⁶⁸ Deficiencies occurred in cases 9, 13, 16, 18, 20, and 21. Cases 9, 13, and 20 had significant deficiencies.

showed an enlarged heart and possible lung fibrosis, neither of which was normal.

- In case 13, the provider evaluated the patient after an emergency room visit for a urinary tract infection. However, the provider did not address the elevated blood-sugar levels from finger-stick tests, which can contribute to urinary tract infections.
- In case 20, the provider reordered the patient's additional dose of an antiseizure medication, but then canceled this order and erroneously stated the order was a "Duplicate Order." Consequently, the patient did not receive the full dosage of antiseizure medication and was at an increased risk of breakthrough seizures.
- Moreover, in case 20, the provider saw the patient for a chronic care visit, documented the patient was taking an increased dose of antiseizure medication twice weekly, and ordered a laboratory test to check for the antiseizure medication blood level. However, the provider did not thoroughly review the MAR to see the patient was no longer receiving the increased dosage of antiseizure medication after the provider had canceled this order the previous month.

Patient Notification Letter

Providers did not always send patient notification letters to patients. When they did, letters did not always contain the four elements required by policy. After providers interpret laboratory results, they are responsible for notifying patients of the laboratory results and of the necessary next steps. We found these types of deficiencies in 13 of the 20 detailed cases we reviewed.⁶⁹ Further discussion can be found in the **Health and Information Management** indicator.

Chronic Care

In many instances, providers appropriately managed patients' chronic health conditions. However, we identified deficiencies related to poor review of records and decision-making.⁷⁰ We discuss these instances of untimely review of coagulation studies and blood-sugar levels from finger-stick tests, and inappropriate management of diabetes, hypertension, and seizure disorder above.

Further discussion of chronic care management of coagulation studies can be found in the **Diagnostic Services** indicator.

Documentation Quality

Documentation is important because it shows the provider's thought-process during clinical decision-making. When contacted by nurses, providers did not always document the interactions. In 10 of the 45 cases we reviewed, our

⁶⁹ Cases 1, 2, 6, 8–12, 14–16, 19, and 20 had deficiencies related to incomplete or missing patient notification letters.

⁷⁰ Deficiencies occurred in cases 1, 6, 8–14, 20. Cases 6, 8, 9, 13, and 20 had significant deficiencies.

clinicians found 12 undocumented interactions and one deficiency related to poor documentation.⁷¹ In 10 of the undocumented interactions, the provider was co-consulted by the nurse.⁷²

Provider Continuity

Provider continuity was generally good, with most providers attending to patients on one yard for long periods of time and, in some cases, for years. Most patients were usually seen by their primary care provider.

Clinician On-Site Inspection

The OIG clinicians observed the weekly provider meeting, which was attended by both in-clinic providers in person and telemedicine providers remotely. The physician on-call gave a report on significant overnight issues. The medical team discussed specific patient care plans and general medical practice updates. OIG clinicians also attended population management meetings wherein medical staff discussed individual patient needs, and at which providers appeared to know their patients well.

The OIG physician met with the CME and the chief physician and surgeon (CP&S) separately, and discussed the institution's vacancy rate. VSP did not have any vacancies at the time of our on-site inspection, but two providers were out on long-term sick leave, and another provider was due to retire imminently. Additionally, the OIG physician was unable to meet with most of the providers who generated the most severe deficiencies. Five of the eight providers were either no longer working for CCHCS or on long-term sick leave.

Another challenge to provider care the medical leadership identified was specialty physicians aging and retiring, which resulted in reduced access to specialty care providers. However, the CME and CP&S reported no difficulty in hiring and retaining providers despite not being able to offer a 15 percent pay differential. They cited VSP's proximity to Highway 99 and the institution's reputation for being well-organized as reasons for experiencing success in retaining providers.

When asked about their morale and the relationship with medical leadership, providers consistently reported high morale and having very good relationships with their CME and CP&S. Providers reported their medical leadership had an "open door policy" and regularly visited providers in their clinics and attended huddles. OIG clinicians attended the OHU huddle and witnessed a code blue alert call come in from the adjacent TTA. Although the dedicated OHU/TTA physician left to attend to this alert, the CP&S was already on scene. The CME also reported the CP&S had previously stepped in to see patients to assist line physicians.

⁷¹ Documentation deficiencies were identified in cases 11, 13, 14, 18, 19, 21, 23, 31, 33, and 42.

⁷² The nurse co-consulted the provider in cases 11, 14, 18, 21, 23, 31, 33, and 42.

Recommendations

- Medical leadership should ascertain causative factors in the untimely provider review of test results. Medical leadership should implement remedial measures as appropriate.
- Medical leadership should remind providers to fully document their co-consultations with nurses in the EHRS.
- Medical leadership should consider reminding providers to review the blood-sugar levels from finger-stick tests of diabetic patients at each visit.

Specialized Medical Housing

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. Our clinicians also interpreted relevant compliance results and incorporated them into this indicator. At the time of our inspection, VSP's specialized medical housing consisted of an outpatient housing unit (OHU).

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
Inadequate
(55.6%)

Results Overview

For the OHU, both providers and nurses provided sufficient patient care. OHU providers generally evaluated patients timely and completed assessments as required. Similarly, OHU nurses mostly performed thorough admission patient assessments, communicated with the providers, and documented as required. Although nurses administered medications as ordered, compliance testing showed the pharmacy did not always fill and dispense medications timely. In addition, during the time of inspection, our compliance team found the call light of the communication system to be nonfunctional. Considering compliance and case reviews, on balance, we rated this indicator **adequate**.

Case Review and Compliance Testing Results

We reviewed 51 events in three OHU cases that included 16 provider events and 20 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundled up to two weeks of patient care into a single event. We identified nine deficiencies, none of which was significant.⁷³

Provider Performance

Providers generally delivered adequate care. Compliance testing showed providers completed most admission history and physical examinations without delay (MIT 13.002, 77.8%). Our clinicians found providers generally made appropriate assessments and decisions, reviewed medical records thoroughly, and addressed specialists' recommendations timely. We identified five deficiencies related to incomplete assessments and questionable decision-making, none of which was significant.⁷⁴

⁷³ We reviewed OHU cases 43–45. Deficiencies occurred in cases 43–45.

⁷⁴ Deficiencies occurred in cases 43–45.

Nursing Performance

SMH nurses provided good patient care. They frequently performed thorough assessments, intervened timely, and documented as required. They performed rounds every shift, ensured patient safety, and notified the provider as needed. Compliance testing showed SMH nurses performed very well in completing initial nursing assessments timely (MIT 13.001, 88.9%). However, case reviewers identified deficiencies in which the nurses did not perform the following: assess vital signs for a patient who returned from an outside appointment, perform a genitourinary assessment, and inquire about the patient's last bowel movement during an admission assessment, provide patient education on the nurse call light, and perform PICC line dressing changes as ordered.⁷⁵

Medication Administration

Case review and compliance testing showed different results. Our clinicians did not identify any deficiencies for medication management in the SMH. However, compliance testing found the institution needs improvement with timely providing medications to the patients on admission to SMH (MIT 13.003, 55.6%). The low score resulted from pharmacy not timely filling and dispensing medications. We discuss these concerns in the **Medication Management** indicator.

Clinician On-Site Inspection

During the on-site visit, 18 of the OHU beds were occupied. The OHU had 20 medical beds and a dedicated provider who was present for the morning huddle. The huddle was well organized, had good attendance, and started on time. During the huddle, the provider left briefly to tend to a medical emergency in the TTA as the OHU provider also covers the TTA. Two RNs are assigned to the OHU on second watch and one LVN is assigned to the first and third watches. Nurses conduct daily rounds on patients and record them on a paper log. To communicate patient care needs between shifts, nursing staff give verbal reports as well as paper copies of reports describing events that happened during the shift. Nursing staff reported the OHU did not have any issues with supplies, equipment, or the pharmacy. They reported their supervisor was available, and custody staff was helpful. Despite that assessment, OHU nursing staff stated nursing morale was only fair. However, they reported being short of staff and that they were often redirected to perform other assignments, which could have been the reason.

⁷⁵ Assessment and education deficiencies occurred in cases 43–45. A PICC is a peripherally inserted central catheter, which is used to provide intravenous access and administer fluids and medication.

Compliance Testing Results

Compliance On-Site Inspection and Discussion

At the time of our on-site inspection, the OHU had a nonfunctional call light communication system (MIT 13.101, N/A).⁷⁶ Although the institution had a local operating procedure in the event the call light system was not working, the OHU nurse whom we interviewed was not aware this local operating procedure existed, which meant the nurse did not perform a safety check for all patients admitted into the OHU (MIT 13.102, zero).

⁷⁶ Unlike the inpatient units that are governed by Title 22, the OHU is not required to have a call light communicating system.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001) *	8	1	0	88.9%
Was a written history and physical examination completed within the required time frame? (13.002) *	7	2	0	77.8%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003) *	5	4	0	55.6%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101) *	0	0	1	N/A
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	0	1	0	0
Overall percentage (MIT 13): 55.6%				

* 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 determining and evaluating causative factors related to the untimely provisions of medications and implement remedial measures as appropriate.
- The nursing leadership should provide training to the OHU nurses about the institution's local operating procedures for the call light communication system.

Specialty Services

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

VSP specialty services yielded differing ratings between compliance and case review. Compliance testing found the institution provided routine-, medium-, and high-priority specialty services to patients as well as routine follow-up specialty appointments within required time frames. Providers also generally saw patients for specialty follow-up appointments on time. However, VSP did not provide timely follow-up high- or medium-priority specialty service appointments. Similarly, VSP did not perform as well with health information management and continuing specialty services for transfer patients. Case review found VSP managed specialty services well overall. Considering compliance and case reviews, on balance, VSP had an **inadequate** rating for this indicator.

Overall
Rating
Inadequate

Case Review
Rating
Adequate

Compliance
Score
**Inadequate
(69.8%)**

Case Review and Compliance Testing Results

The OIG clinicians reviewed 81 events related to this indicator, which included 60 specialty consultations and procedures, and 17 nursing encounters. There were 16 deficiencies in this category, four of which were considered significant.⁷⁷

Access to Specialty Services

VSP's access to specialists varied. Compliance testing showed the institution provided timely high-priority (MIT 14.001), medium-priority (MIT 14.004), and routine-priority (MIT 14.007) specialty appointments, all at a rate of 86.7 percent. Similarly, compliance testing found the institution provided timely subsequent follow-up routine-priority specialty appointments (MIT 14.009, 88.9%). However, VSP struggled with providing subsequent follow-up specialty appointments for high-priority (MIT 14.003, 57.1%) and medium-priority (MIT 14.006, 50.0%) requests within the required time frame. VSP only ensured specialty access for half the patients who transferred into the institution with a preapproved specialty request (MIT 14.010, 50.0%). Case reviewers found two deficiencies with specialty access, neither of which was considered significant.⁷⁸

⁷⁷ Deficiencies occurred in cases 9, 10, 13–15, 16, 18, 22, 23, 43, and 44. Cases 10 and 14 had significant deficiencies.

⁷⁸ Deficiencies occurred in cases 10 and 16.

Provider Performance

Providers generally ordered appropriate specialty consults and followed specialty recommendations. We found six deficiencies related to untimely provider endorsement with one significant deficiency as illustrated below:⁷⁹

- In case 14, the HIM staff scanned the consultation report into the EHRS. However, the provider endorsed the report 10 days later.

Nursing Performance

We reviewed 17 nursing events in eight cases in which patients returned to the institution after specialty procedures and consultations. Overall, nurses frequently performed good assessments, reviewed specialty reports, communicated with the provider as necessary, and documented as required. We did not identify any significant deficiencies. Deficiencies we did identify were related to assessments.⁸⁰

Health Information Management

Compliance testing showed providers struggled with the timely review of specialty reports for routine-priority (MIT 14.008, 71.4%), medium-priority (MIT 14.005, 46.7%), and high-priority (MIT 14.002, 71.4%) services. However, VSP scanned specialty reports into the EHRS in a timely manner (MIT 4.002, 93.6%). Case review found some minor deficiency patterns in specialty HIM. There were 12 HIM deficiencies of different types: three were delayed or mislabeled scans, three were not properly forwarded to the provider for review, and six were endorsed by the provider late.⁸¹

Further discussion is located under the **Health Information Management** indicator.

Clinician On-Site Inspection

We discussed specialty HIM processes with VSP's health records technician (HRT) supervisor and nursing supervisors. The HRT supervisor reported the utilization management (UM) nurse or specialty office technicians dropped off reports from off-site specialty appointments to the HIM department. HIM staff, in turn, scanned the off-site reports into the EHRS and routed them to providers for review.

We met with two SRNs who were filling in for the specialty nurse to discuss specialty services care. They reported the area had lost on-site gastroenterology services and was also having difficulty securing dietary consultation services due to a backlog. The closure of one community hospital had also affected the

⁷⁹ Deficiencies occurred in cases 13, 14, 18, 22, 23, and 44. Case 14 had a significant deficiency.

⁸⁰ We reviewed the following specialty cases for nursing encounters: 10, 14, 18, 21–23, 43, and 44. Deficiencies occurred in cases 23 and 43.

⁸¹ Deficiencies occurred in cases 9, 10, 13–15, 18, 22, 23, and 44. Cases 10 and 14 had significant deficiencies.

institution's ability to provide specialty care. When asked about who in their area tracked request for service (RFS) and specialty follow-up appointments, they informed us VSP used an internal tracking system in Microsoft Excel software. Upon the patient's return from an off-site specialty appointment, the TTA nurse reviewed the recommendations and communicated via EHRS with the specialty nurse and the patient care team about the recommendations. The medical team would then discuss the specialty return patient during the morning huddle and place orders under the direction of the provider.

Compliance Testing Results

Table 18. 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) *	13	2	0	86.7%
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) *	10	4	1	71.4%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	4	3	8	57.1%
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) *	13	2	0	86.7%
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) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	1	1	13	50.0%
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) *	13	2	0	86.7%
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) *	10	4	1	71.4%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	8	1	6	88.9%
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) *	10	10	0	50.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	13	6	0	68.4%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	14	5	0	73.7%
Overall percentage (MIT 14): 69.8%				

* 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 19. 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) *,†	34	6	5	85.0%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	29	2	14	93.6%

* 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

- Medical leadership should identify the root cause(s) of untimely completion of subsequent, specialty follow-up appointments for high and medium-priority services and implement remedial measures as appropriate.
- Medical leadership should identify the root cause(s) of untimely completion of transfer patients' specialty appointments and implement remedial measures as appropriate.
- Medical leadership should ascertain the challenges in the untimely receipt of specialty reports and the untimely provider review of these reports and implement remedial measures as appropriate.

Administrative Operations

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 required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, our inspectors determined 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 based on the compliance score. Our case review clinicians did not rate this indicator.

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

Overall
Rating
Adequate

Case Review
Rating
(N/A)

Compliance
Score
**Adequate
(77.6%)**

Results Overview

VSP's performance was mixed in this indicator. The institution scored well in some applicable tests; however, the institution could improve in several areas. The Emergency Medical Response Review Committee (EMRRC) did not complete event checklists, or the review was not completed timely. In addition, the institution did not conduct live medical emergency response drills and had incomplete documentation. The nurse educator did not ensure nurses who administered medication had completed their annual competency testing in a timely manner. Physician managers did not always complete probationary and annual performance appraisals in a timely manner. These findings are set forth in the table below. We rated this indicator **adequate**.

Compliance Testing Results

Nonscored Results

We reviewed VSP's root cause analysis (RCA) of reported incidents. During our review period, VSP submitted two reports to the CCHCS Health Care Incident Review Committee (HCIRC). We found one RCA report remained incomplete and was still awaiting HCIRC approval. The remaining RCA report was granted an extension for completion, but the deadline was beyond the OIG review period; therefore, this RCA was not assessed (MIT 15.001).

Our testing period reviewed mortality reports completed both before and after the effective revision date of the CCHCS mortality review policy requirements. Prior to May 2022, we obtained CCHCS Death Review Committee (DRC) reporting data. Three unexpected (Level 1) and two expected (Level 2) deaths

occurred during our review period. In our inspection, we found the DRC did not complete any death review reports promptly. The DRC finished four reports 18 to 133 days late and submitted the reports to the institution's CEO 11 to 126 days late. The remaining report was overdue at the time of the OIG's inspection. Effective May 2022, we obtained CCHCS Mortality Case Review reporting data. At the time of our inspection, for three patients, we found no evidence in the submitted documentation of the Preliminary Mortality Report having been completed. These three reports were overdue at the time of the OIG's inspection. For the remaining report, the compliance date was beyond the OIG's review period; therefore, this was not assessed (MIT 15.998).

Compliance Testing Results

Table 20. 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) *	This is a nonscored test. Please refer to the discussion in this indicator.			
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)	6	6	0	50.0%
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 patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	7	2	0	77.8%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	6	4	0	60.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	3	4	1	42.9%
Did the providers maintain valid state medical licenses? (15.106)	12	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, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (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? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality 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): 77.6%				

* 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.

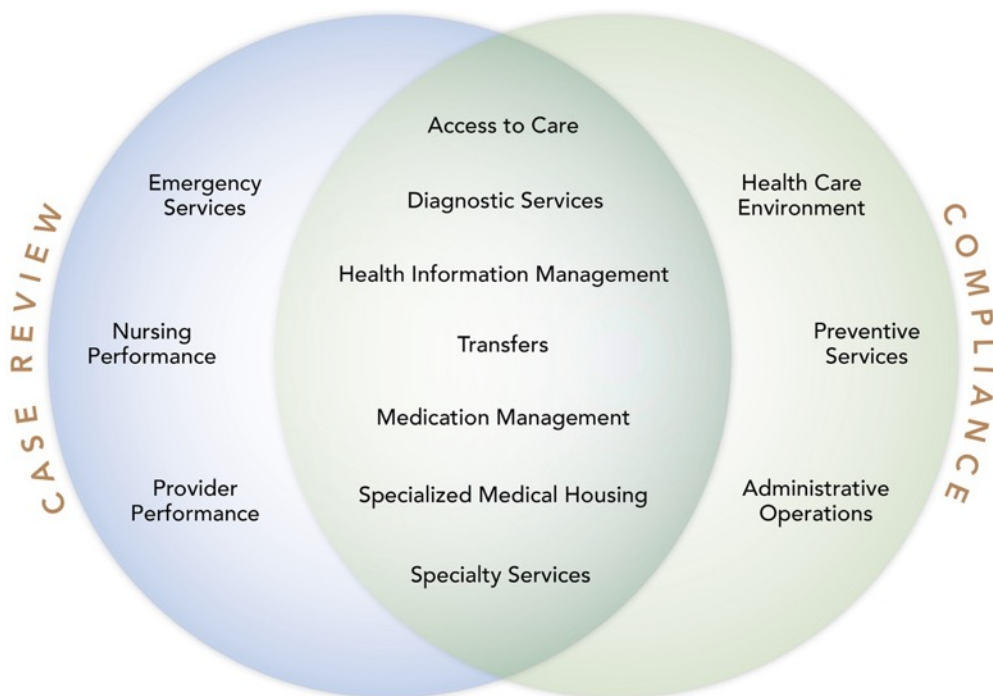
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Appendix A: Methodology

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 Review Distribution for VSP



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 7 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

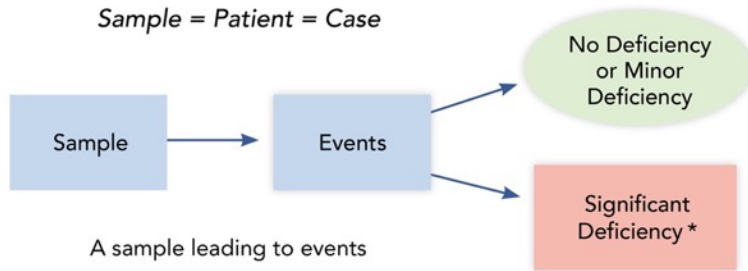
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review **events**. Our clinicians also record medical errors, which we refer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

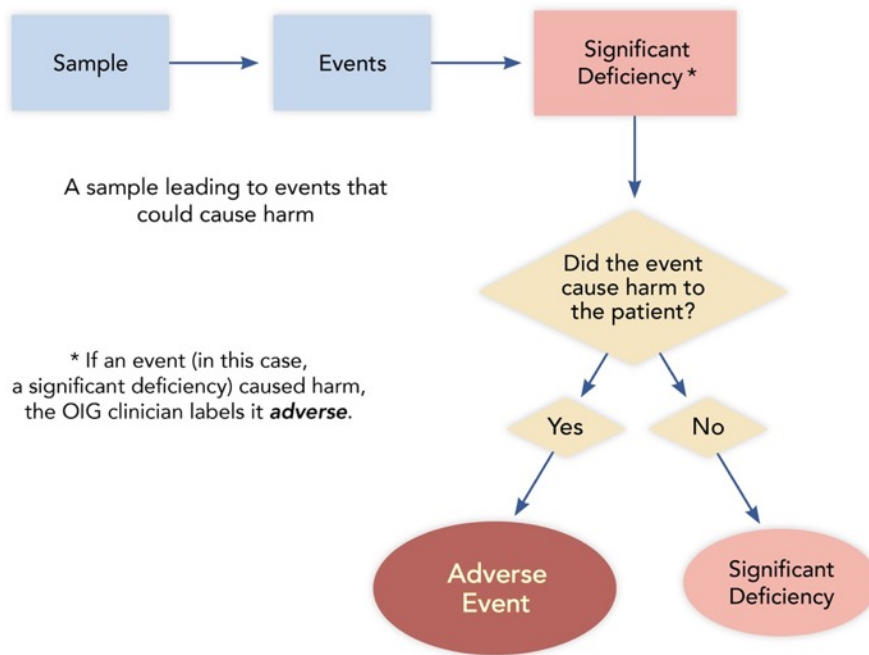
Figure A–2. Case Review Testing

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**.



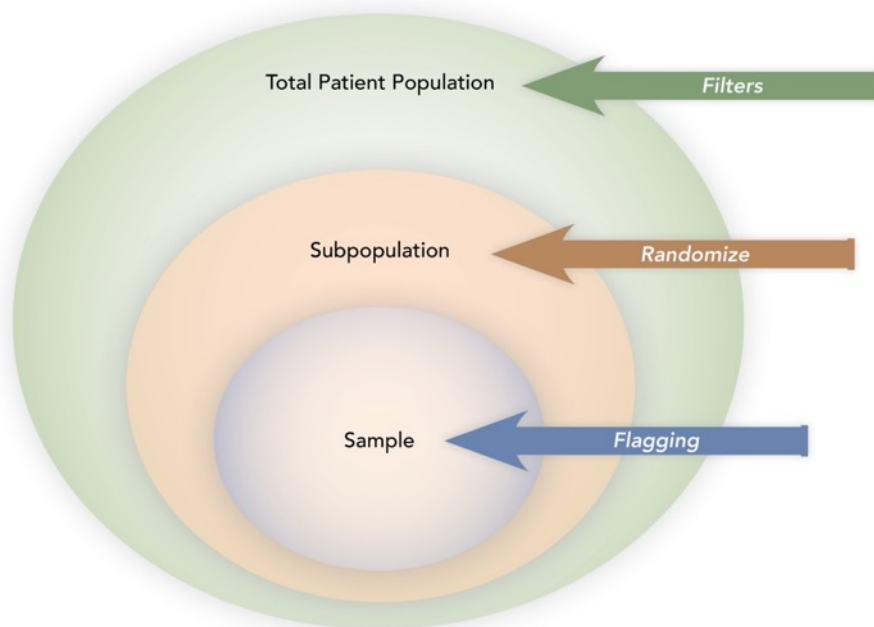
Source: The Office of the Inspector General medical inspection analysis.

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. VSP Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
OHU	3
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services – CPR	3
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	13
Specialty Services	2
	45

Table B–2. VSP Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	3
Anticoagulation	3
Arthritis/Degenerative Joint Disease	3
Asthma	7
COPD	6
COVID-19	4
Cancer	3
Cardiovascular Disease	5
Chronic Kidney Disease	1
Chronic Pain	11
Cirrhosis/End-Stage Liver Disease	3
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	11
Gastroesophageal Reflux Disease	14
Hepatitis C	7
Hyperlipidemia	22
Hypertension	20
Mental Health	24
Migraine Headaches	1
Seizure Disorder	2
Sleep Apnea	5
Substance Abuse	5
Thyroid Disease	1
	162

Table B–3. VSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	217
Emergency Care	38
Hospitalization	15
Intrasystem Transfers In	17
Intrasystem Transfers Out	15
Outpatient Care	375
Specialized Medical Housing	51
Specialty Services	83
	811

Table B–4. VSP Case Review Sample Summary

Clinician	Total
MD Reviews Detailed	20
MD Reviews Focused	6
RN Reviews Detailed	12
RN Reviews Focused	32
Total Reviews	70
Total Unique Cases	45
Overlapping Reviews (MD & RN)	25

Appendix C: Compliance Sampling Methodology

Valley State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Access to Care</i>				
MIT 1.001	Chronic Care Patients	25	Master Registry	<ul style="list-style-type: none"> Chronic care conditions (at least one condition per patient—any risk level) Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	<ul style="list-style-type: none"> See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	<ul style="list-style-type: none"> Clinic (each clinic tested) Appointment date (2–9 months) Randomize
MIT 1.007	Returns From Community Hospital	21	OIG Q: 4.005	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	<ul style="list-style-type: none"> Randomly select one housing unit from each yard
<i>Diagnostic Services</i>				
MITs 2.001–003	Radiology	10	Radiology Logs	<ul style="list-style-type: none"> Appointment date (90 days–9 months) Randomize Abnormal
MITs 2.004–006	Laboratory	10	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
MITs 2.010–012	Pathology	10	InterQual	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Service (pathology related) Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Health Information Management (Medical Records)</i>				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	<ul style="list-style-type: none"> • Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	<ul style="list-style-type: none"> • Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	21	OIG Q: 4.005	<ul style="list-style-type: none"> • Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	<ul style="list-style-type: none"> • Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	21	CADDIS off-site admissions	<ul style="list-style-type: none"> • Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
<i>Health Care Environment</i>				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	9	OIG inspector on-site review	<ul style="list-style-type: none"> • Identify and inspect all on-site clinical areas.
<i>Transfers</i>				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	<ul style="list-style-type: none"> • Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	2	OIG inspector on-site review	<ul style="list-style-type: none"> • R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Pharmacy and Medication Management</i>				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See Access to Care <ul style="list-style-type: none"> At least one condition per patient—any risk level Randomize
MIT 7.002	New Medication Orders	25	Master Registry	<ul style="list-style-type: none"> Rx count Randomize Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	21	OIG Q: 4.005	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	<ul style="list-style-type: none"> Date of transfer (2–8 months) To location/from location (yard to yard and to/from ASU) Remove any to/from MHCB NA/DOT meds (and risk level) Randomize
MIT 7.006	En Route	10	SOMS	<ul style="list-style-type: none"> Date of transfer (2–8 months) Sending institution (another departmental facility) Randomize NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	<ul style="list-style-type: none"> Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	21	Medication error reports	<ul style="list-style-type: none"> All medication error reports with Level 4 or higher Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	3	On-site active medication listing	<ul style="list-style-type: none"> KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Prenatal and Postpartum Care</i>				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	<ul style="list-style-type: none"> • Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	<ul style="list-style-type: none"> • Arrival date (2–12 months) • Earliest arrivals (within date range)
<i>Preventive Services</i>				
MITs 9.001–002	TB Medications	9	Maxor	<ul style="list-style-type: none"> • Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	<ul style="list-style-type: none"> • Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	<ul style="list-style-type: none"> • Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	<ul style="list-style-type: none"> • Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Reception Center</i>				
MITs 12.001–007	RC	N/A at this institution	SOMS	<ul style="list-style-type: none"> Arrival date (2–8 months) Arrived from (county jail, return from parole, etc.) Randomize
<i>Specialized Medical Housing</i>				
MITs 13.001–003	Specialized Health Care Housing Unit	9	CADDIS	<ul style="list-style-type: none"> Admit date (2–8 months) Type of stay (no MH beds) Length of stay (minimum of 5 days) Rx count Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	<ul style="list-style-type: none"> Specialized Health Care Housing Review by location
<i>Specialty Services</i>				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> Approval date (3–9 months) 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 Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> Approval date (3–9 months) 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 Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> Approval date (3–9 months) 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 Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Specialty Services (continued)</i>				
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	<ul style="list-style-type: none"> Arrived from (other departmental institution) Date of transfer (3–9 months) Randomize
MITs 14.011–012	Denials	19	InterQual	<ul style="list-style-type: none"> Review date (3–9 months) Randomize
		N/A	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> Meeting date (9 months) Denial upheld Randomize
<i>Administrative Operations</i>				
MIT 15.001	Adverse/sentinel events	2	Adverse/sentinel events report	<ul style="list-style-type: none"> Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	<ul style="list-style-type: none"> Monthly meeting minutes (6 months)
MIT 15.004	LGB	N/A at this institution	LGB meeting minutes	<ul style="list-style-type: none"> Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	<ul style="list-style-type: none"> Most recent full quarter Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	<ul style="list-style-type: none"> Medical grievances closed (6 months)
MIT 15.103	Death Reports	9	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> Most recent 10 deaths Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	<ul style="list-style-type: none"> On duty one or more years Nurse administers medications Randomize
MIT 15.105	Provider Annual Evaluation Packets	8	On-site provider evaluation files	<ul style="list-style-type: none"> All required performance evaluation documents
MIT 15.106	Provider Licenses	12	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	<ul style="list-style-type: none"> All staff Providers (ACLS) Nursing (BLS/CPR) Custody (CPR/BLS)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Administrative Operations (continued)</i>				
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	<ul style="list-style-type: none"> All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	<ul style="list-style-type: none"> New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	9	OIG summary log: deaths	<ul style="list-style-type: none"> Between 35 business days & 12 months prior California Correctional Health Care Services mortality reviews

February 13, 2024, California Correctional Health Care Services' Response Letter to the OIG's Medical Inspection Report for VSP

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February 13, 2024

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

Dear Ms. Singh:

California Correctional Health Care Services (CCHCS) has reviewed the draft Medical Inspection Report for Valley State Prison (VSP) conducted by the Office of the Inspector General (OIG) from June 2022 to November 2022. During this timeframe, 10,500 primary care provider (PCP) encounters, not including Triage and Treatment Area visits, were completed. In contrast, the OIG inspection reviewed approximately 1% or 113 PCP encounters, which are not indicative of the quality of care delivered to the patient population at VSP.

If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,



DocuSigned by:
DeAnna Gouldy
3B7F6B95AC0A4D1...
DeAnna Gouldy
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
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
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region II, CCHCS
Chief Executive Officer, VSP
Heather Pool, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Amanda Elhardt, Report Coordinator, OIG



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
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February 16, 2024, OIG Response to February 13, 2024, Letter Regarding VSP Report

STATE of CALIFORNIA
OIG | OFFICE of the
 INSPECTOR GENERAL
 Independent Prison Oversight

Amarik K. Singh, Inspector General
 Neil Robertson, Chief Deputy Inspector General

Regional Offices

Sacramento
 Bakersfield
 Rancho Cucamonga

February 16, 2024

DeAnna Gouldy
 Deputy Director
 Policy and Risk Management Services
 California Correctional Health Care Services

Dear Ms. Gouldy:

OIG RESPONSE TO FEBRUARY 13, 2024, CCHCS LETTER REGARDING VSP REPORT

The Office of the Inspector General (OIG) received your February 13, 2024, Response Letter to the OIG's Cycle 7 Draft Medical Inspection Report for Valley State Prison (VSP) following CCHCS's opportunity to engage in the OIG medical inspections report disputes process. In your Response Letter, you noted more than 10,500 primary care provider (PCP) encounters were completed during the time period of the VSP medical inspection from June 2022 to November 2022. Since the OIG's Medical Inspection Unit (MIU) reviewed 113 PCP encounters or approximately 1% of the encounters completed, you expressed the opinion the OIG findings are not indicative of the quality of care delivered to the patient population at VSP.

The OIG respectfully disagrees with your assertion. In developing the case review aspect of the OIG medical inspection process in 2014 with each of our stakeholders, including CCHCS, the OIG contracted with the Mathematics and Statistics Department of California State University, Sacramento (CSUS). The purpose of the contract was for CSUS to determine whether the sample selection and sizes proposed for the retrospective case review component of the OIG medical inspections was adequate based on the OIG's proposed methodology. On July 2, 2014, the OIG met with Michelle Norris, Ph.D., Department of Mathematics and Statistics, CSUS, to discuss the proposed methodology. Following that meeting, in August 2014, CSUS issued its report titled "Office of the Inspector General Medical Inspections Unit Retrospective Case Review Sample Size Considerations."

In this report, CSUS Mathematics and Statistics Department opined, "The MIU has carefully described the rationale for the selection of patients for case review where the targeted patients are typically patients who use the medical care component under study most frequently or have the most serious medical conditions. This is a purposeful sample designed to yield the maximum

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Ms. DeAnna Gouldy, Deputy Director
 February 16, 2024
 Page 2


amount of information for the number of inmate-patients sampled.” CSUS next described the difference between quantitative and qualitative studies, noting “Precise sample size calculations are applicable to studies where data from probability-based samples are used to estimate well-defined population values such as the proportion of inmates receiving necessary preventative diagnostic tests in a timely manner. . . . [T]he sample sizes required for any reasonable level of precision would be too large for MIU clinicians to conduct the detailed qualitative analyses needed to identify deficiencies in the overall performance of the medical care system. Since the case study is qualitative, the concept of saturation is a more appropriate basis for sample size determination.”

CSUS further clarified, “In the Retrospective Case Review study, the principle of saturation means that clinicians should conduct as many case reviews as are necessary to capture the important deficiencies in the medical care system. Thus, if clinicians have a sense of the systemic deficiencies after 5 case reviews, then that is a large enough sample size. If additional case reviews are likely to yield the same deficiencies, then you have achieved saturation and additional sampling is an inefficient use of resources.” Ultimately, CSUS concluded, “[T]he [OIG’s] method seems quite appropriate to the goal of identifying deficiencies in the overall medical care system.”

Following this analysis, the OIG adopted the proposed methodology during Cycle 4 of the OIG’s medical inspection process. Subsequently, on November 16, 2016, the OIG met with all stakeholders, including CCHCS, to revisit the OIG medical inspection methodology. At this meeting, the parties agreed to changes to the methodology, but found the updated methodology continued to meet the saturation required for a qualitative analysis sample size. Moreover, at the beginning of both Cycle 6 and Cycle 7, the MIU invited comments on the current methodology, which has remained consistent since Cycle 5. The legitimacy of the sample size for conducting comprehensive retrospective case reviews has never been at issue.

Therefore, the OIG disagrees with the assertion that our case review sampling is not sufficient for the OIG’s MIU to reach findings indicative of the quality of care that VSP’s health care system is providing to the incarcerated population. In contrast, by using the principle of statistical saturation for qualitative analysis, as recommended by the Mathematics and Statistics Department of CSUS, the current retrospective case sampling methodology is appropriate for the MIU clinicians to accurately assess the quality of medical care each institution is providing. As such, the OIG stands behind both our methodology and our findings in the Cycle 7 Draft Medical Inspection Report for VSP.

Sincerely,


 Amarik Singh (Feb 16, 2024 10:48 PST)

Amarik Singh
 Inspector General
 Office of the Inspector General

Ms. DeAnna Gouldy, Deputy Director
February 16, 2024
Page 3

cc: Clark Kelso, Federal Receiver
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
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Regional Executives, Region II, CCHCS
Chief Executive Officer, VSP
Medical Inspection Unit Management Team, OIG
Shaun Spillane, Chief Counsel, OIG

Cycle 7
Medical Inspection Report
for
Valley State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
February 2024

OIG