Salinas Valley State Prison (SVSP)
Health Care Evaluation

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Introduction

In September 2012, the Federal Court, in Order Re: Receivership Transition Plan and Expert Evaluations requested that the Court medical experts conduct evaluations at each CDCR prison to determine whether an institution is in substantial compliance. The Order contemplates that an institution "shall be deemed to be in substantial compliance, and therefore constitutionally adequate, if it receives an overall OIG score of at least 75% and an evaluation from at least two of the three court experts that the institution is providing adequate care."

To prepare for the prison health evaluations, in December 2012 the medical experts participated in a series of meetings with Clark Kelso, Receiver, and California Correctional Health Care Services (CCHCS) and CDCR leadership to familiarize ourselves with structural changes that have occurred in the health care system since the beginning of the Receivership. Information gained from these meetings was invaluable to us in planning and performing the evaluations, and we express our appreciation to Mr. Kelso, CCHCS and CDCR.

In conducting the reviews, the medical experts evaluated essential components to an adequate health care system. These include organizational structure, health care infrastructure (e.g., clinical space, equipment, etc.), health care processes and the quality of care.

Methods of assessment included:

- Interviews with health care leadership and staff and custody staff;
- Tours and inspection of medical clinics, medical bed space (e.g. Outpatient Housing Units, Correctional Treatment Centers, etc.) and administrative segregation units;
- Review of the functionality of business processes essential to administer a health care system (e.g., budget, purchasing, human resources, etc.);
- Reviews of tracking logs and health records;
- Observation of health care processes (e.g. medication administration);
- Review of policies and procedures and disease treatment guidelines;
- Review of staffing patterns and professional licensure; and
- Interviews with inmates.

With respect to the assessment of compliance, the medical experts seek to determine whether any pattern or practice exists at an institution or system-wide that presents a serious risk of harm to inmates that is not being adequately addressed.[1]

To evaluate whether there is any pattern or practice that presents a serious risk of harm to CDCR patients, our methodology includes review of health records of patients with serious

[1] Order re: Receivership Transition Plan and Expert Evaluations No. C01-1351 TEH, 9/5/12.

medical conditions using a "tracer" methodology. Tracer methodology is a systems approach to evaluation that is used by the Joint Commission for Accreditation of Health Care Organizations. The reviewer traces the patient through the organization's entire health care process to identify whether there are performance issues in one or more steps of the process, or in the interfaces between processes.

The experts reviewed records using this methodology to assess whether patients were receiving timely and appropriate care, and if not, what factors contributed to deficiencies in care. Review of any given record may show performance issues with several health care processes (e.g., medical reception, chronic disease program, medication issues, etc.). Conversely, review of a particular record may demonstrate a well-coordinated and functioning health care system; as more records are reviewed, patterns of care emerge.

We selected records of patients with chronic diseases and other serious medical conditions because these are the patients at risk of harm and who use the health care system most regularly. The care documented in these records will demonstrate whether there is an adequate health care system.

The tracer methodology may also reflect whether any system-wide issues exist. Our methodology includes a reassessment of the systemic issues that were described in the medical experts report to Judge Henderson in April 2006 at the time the system was found to be unconstitutional and whether those systemic issues have been adequately addressed.[2]

We are available to discuss any questions regarding our audit methodology.

[2] The Status of Health Care Delivery Services in CDCR Facilities. Court-Appointed Medical Experts Report. April 15, 2006.

Overall Finding

We find that Salinas Valley State Prison (SVSP) is not providing adequate medical care to patients, and that there are systemic issues that present an on-going serious risk of harm to patients and result in preventable morbidity and mortality.

Executive Summary

On June 4-8, 2013, the Plata Court Medical Experts visited Salinas Valley State Prison (SVSP) to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results, Cycle 3 report showing that SVSP had an overall score of 87.7% in December 2012. This report describes our findings and recommendations. We thank Warden Randy Grounds, Chief Executive Officer Charles Young and their staff for their assistance and cooperation in conducting the review.

At SVSP, we found serious problems related to access, timeliness, and quality of care. Clinical systems that we found to be deficient included the intrasystem transfer process, nursing sick call, chronic disease management, urgent/emergent care, specialty services, and medication administration. The most significant concern related to access to care was quality of provider evaluations and delays in care for routine and urgent consultations. Delays in patient evaluations resulted in deterioration and unnecessary hospitalizations. We note that CCHCS quality data reports indicate that SVSP had 50% more preventable hospitalizations than the state-wide average.

We found serious problems with the intrasystem transfer process in terms of continuity of care. In addition, following arrival at SVSP, medical care was often fragmented and of poor quality. Nurses did not consistently document vital signs and weight for patients with chronic diseases and pharmacy staff renewed medication orders from the sending facility without review and signature by an SVSP provider. Furthermore, nursing referrals often did not occur timely and the provider's initial evaluations were often cursory. Physicians discontinued medications without clinically evaluating or discussing treatment changes with the patient.

We found significant problems with management of chronic disease patients related to the timeliness and quality of care. The care is often incomplete and fragmented. We also found major issues related to the use of opiates for pain management. Given the problems we found, as well as those related to access to care noted above, it is not surprising that over half of physicians at SVSP are under monitoring or supervision via peer review.

Administratively, SVSP lacks adequate health care leadership. Most of the executives work half time at SVSP, sharing responsibilities with other facilities. In addition to leadership positions being half time, there has been considerable turnover in key positions.

Operationally, while the CTC patient rooms, showers and halls were clean and sanitized, the TTA and yard clinics were not clean or well-sanitized. We also found the exam areas to be cluttered and not well-organized. There is no effective periodic automatic replacement (PAR) system, and many of the clinical areas are cluttered with excess supplies. There is no effective system for tracking materials and supplies, which has resulted in a large excess inventory.

Problems also exist related to the care being provided at the CTC. In 2011, the CTC received a negative review by the California Department of Health (CDPH). At the time of our visit, the unit was clean, well-organized, and sanitized. However, we did find serious problems related to inadequate record keeping, lack of appropriate nursing plans, and fragmented medical care.

We found significant problems with physician peer review and discipline. We have no confidence that peer review at SVSP is effective because of lack of local operating procedures, SVSP management confusion regarding the role of the Office of Internal Affairs (OIA) with respect to physician discipline for clinical matters, and failure to monitor physician practice based on CCHCS monitoring requirements. We also note SVSP and CCHCS failure to track and maintain peer review files locally and at Professional Practice Executive Committee (PPEC) offices; as well as failure to integrate Court-ordered privileging procedures into existing CCHCS procedure. We found a significant number of cases of substandard care which have not been subjected to peer review.

We found problems similar to the ones we found in other facilities, with the disciplinary process. At the time of our visit, there were 19 pending disciplinary cases, including two involving physicians for clinical issues that had been ongoing for 17 months. Due to the length of time it takes to complete the process, there are two nurses working in non-clinical positions because their supervisors do not trust them to be involved in patient care activities. Not only is this wasteful; it prevents the manager from being able to hire someone else into the position. We are concerned that the disciplinary process related to the CTC is not consistent with the 2008 Court order on physician competency and are concerned about the effect of this on potential physician discipline.

SVSP has a large number of policies, some of which are outdated and/or not consistent with other policies. A particular concern is that the warden at SVSP is noted to be the final authority for approval for all of the local operating procedures (including clinical ones) instead of the CEO or CME.

In conclusion, we find that there are serious systemic and clinical practice issues at Salinas Valley State Prison. We believe that the majority of negative patient outcomes are directly attributable to the lack of appropriate medical care provided by physicians, and reflects weaknesses in the CCHCS and institutional credentialing and peer review processes. We believe that CCHCS should take immediate steps to ensure that physicians that do not provide adequate medical care are not permitted to treat CDCR patients.

Findings

Facility Description

The mission of Salinas Valley State Prison (SVSP) is to provide long-term housing and services for Level I to Level IV inmates. SVSP was constructed to meet the access requirements of the Americans with Disabilities Act (ADA). The housing of these inmates is accomplished on a Minimum Support Facility (MSF) Unit, two 270 design facilities and two 180 design facilities. SVSP also houses inmates who meet the criteria of the Department's Disabilities Placement Program. SVSP has a 100 cell stand-alone Administrative Segregation Unit (ASU) and a Correctional Treatment Center (CTC). SVSP provides Correctional Clinical Case Management (CCCMS), Enhanced Outpatient Program (EOP) and Mental Health Bed Crisis (MHBC) services. In addition, the Salinas Valley Psychiatric Program (SVPP), a 370-bed inpatient intermediate care program operated by the Department of State Hospitals (DSH), is located within the secure perimeter. SVPP provides mental health services, 24 hours per day, to adult male correctional inmates who suffer from a major mental illness that has diminished their ability to function within a prison environment.[3]

The design capacity of SVSP is 2,452. At the time of our site visit, the population was 3,466, 141.4% of design capacity.

Organizational Structure and Health Care Leadership

Methodology: We interviewed facility health care leadership and reviewed tables of organization, health care and custody meeting reports, and quality improvement reports.

Findings: SVSP lacks adequate health care leadership. The Interim Chief Executive Officer (CEO), Chief Medical Executive (CME), Chief Support Executive (CSE), Chief Nursing Executive (CNE), and Pharmacist-in-Charge (PIC) all have responsibilities at other facilities. All other executives have responsibilities at the Correctional Training Facility (CTF). Most of the executives work half time at SVSP. In addition to leadership positions being half time, there has been considerable turnover in key positions described below.

Charles Young was the Interim CEO at the time of our review and had held his position for two months. Prior to Mr. Young, Gerald Ellis had been CEO at both SVSP and CTF since 2010 but is now CEO only at CTF. Mr. Young is also the CEO at Pleasant Valley State Prison (PVSP) and Avenal State Prison (ASP). Before that, he had been at High Desert State Prison (HDSP) for 2.5 years. Before CDCR, he was CEO of a county hospital. While Mr. Young appears to be a competent executive, he was filling a consultant role at SVSP on a short-term assignment. He was specifically sent to SVSP on a 120-day basis to do a program assessment and to realign management in keeping with CCHCS goals. Due to his responsibilities at PVSP and ASP, he distributed his time between the three facilities. At SVSP, he focused on developing a plan of action to improve leadership. During his limited tenure he made efforts to create mental

[3] CDCR Website. Salinas Valley State Prison description. July 2013.

health and medical collaboration, leadership teams, implement a quality improvement program, and develop individual leadership. He structured the medical program on moving management decisions into QI committees and attempting to get the right person in the right position. Subsequent to our site visit, Mr. Brian Wilson has been appointed as CEO.

The CME, Dr. Anise Adams, has been in her position for about a year, transferring from Lancaster. Dr. Adams is a well-trained physician. Unfortunately, she has executive assignments at CTF and SVSP, both of which have problems. At SVSP, she manages a group of physicians of whom five of eight are currently under some type of monitoring due to poor clinical performance. Managing this alone would be challenging, however, performing this assignment in addition to managing CTF is a near impossible assignment for a CME. She spends only half her working time at SVSP but SVSP should be a full time assignment.[4] Over the past four years there have been four different Chief Medical Executives at this facility.

The Chief Nursing Executive (CNE), Mike Byrnes, was Interim Director of Nursing (DON) when he was appointed in January 2012 to his current position. Mr. Byrnes appears to be a competent leader in a very difficult assignment and has been the longest tenured and most consistently effective leader at SVSP over the past several years. There have been many changes in nursing leadership at SVSP and the situation has not yet stabilized. Before the CNE position was created as part of the realignment process, the DON was the chief nurse leadership position at SVSP. This position is now filled on an interim basis by Chris Flynn, who has been in the position for about two months. The prior DON at SVSP was redirected to be an appeals coordinator at CTF in February of 2011 because of problems with a survey by the Department of Public Health that identified poor care on the CTC. This person subsequently retired and Mr. Byrnes took the position on an interim basis. In January 2012, when Mr. Byrnes became CNE, the DON position at SVSP again became vacant. At that time the Director of Nursing position at CTF was filled by a person who was being investigated by the California Nursing Board. The realignment process eliminated the DON position at CTF in 2012 and, because of personnel rules, the DON at CTF transferred into the vacated DON position at SVSP. She worked in this position until 4/22/12, when she left on medical leave. She is expected to return soon, but she had been performing as DON while still under investigation by the California Nursing Board. Her investigation by the California Nursing Board is not yet complete. While she is on leave, Chris Flynn is acting in her position as an interim.

The CSE, Shaka Camara, has been in his position since November 2011. He has been with the state since 1994, working in business services with CDCR and as a hospital administrator for the California Department of Veterans Affairs. He currently is the most senior administrative executive at SVSP with a history of the facility. His ability to manage operations is limited by the fact that he only works there half time.

[4]On 8/1/13, we were informed that Dr. Adams is now only responsible for SVSP.

The Chief Physician and Surgeon (CPS) position is vacant because the prior incumbent stepped down to a staff position. Ostensibly, the reason for this was that she could earn more as a staff physician than as a CPS. Since April 2013, Dr. Darren Bright (the current CPS at CTF) has been assigned to help at SVSP as the Interim CPS. He has applied for the permanent position.

Physician leadership has been unstable for years. Over the last four years, there have been four different CMEs: Dr. Sepulveda, Dr. Kumar (as an interim CME), Dr. Kiel, and over the past year, Dr. Adams. The CPS position has not been stable either, with Dr. Kumar recently leaving as CPS to be replaced on an interim basis by Dr. Bright. This revolving leadership has had consequences in terms of physician management. Peer review is largely delegated by Central Office of CCHCS to local leadership, specifically the CME. Based on a discussion with Central Office staff, each of the four recent CMEs has had a different perspective on how peer review should be performed, including the extent to which the CME wanted control of the supervision as opposed to wanting Central Office to take responsibility for managing peer review of physicians. This lack of standardized performance of peer review has resulted in gaps in peer review which still burden the facility.

The PIC is Tony Tran. As with other members of the leadership, his time is shared between SVSP and CTF.

The operational problems at SVSP are well-documented and known to CCHCS. SVSP received a negative review by the California Department of Health in 2011 related to the licensed CTC unit, over half of physicians are under monitoring or supervision via peer review, and there has been a high turnover of executive positions. In addition, the neighboring CTF facility has had a serious issue with drug diversion by staff that generated much publicity, and management indicated that they believed the problem extended to SVSP as well. Two nurses are currently under disciplinary proceedings, in part for diversion. Additionally, while SVPP is a DSH facility, it operates under the CTC license of SVSP. This has resulted in operational problems, especially with the California Department of Public Health regulations related to CTC licensing, credentialing, and management of its organized medical staff. Because of these challenges, a strong and experienced chief executive is needed. However, the current leadership team is composed of individuals who are either interim or only work part-time at the facility.

The SVSP administrative table of organization is organized along functional lines of authority. The CEO reports to Dr. Tharratt for medical issues. He has responsibilities related to dental and mental health for which he works with Dr. Tim Belavich, Statewide Director of Mental Health, and Dr. Mort Rosenburg, Statewide Dental Director. As with other facilities, the CEO operates independently with frequent phone conversations with Central Office, particularly with Mitzi Higashidani on business issues. There are quarterly Chief Executive Officer meetings in Sacramento and periodic meetings with Chief Medical and Nursing Executives. He also has frequent conference calls with Dr. Tharratt several times a month. There are also two weekly conference calls for Chief Executive Officers. One is with Dr. Tharratt and one is a business call with Mitzi Higashidani. At the time of our review Dr. John Zweifler was the Chief Deputy

Regional Medical Executive who regularly came to the facility but not on a scheduled basis. However, Dr. Zweifler recently left state employment and Dr. Robert Chapnick is currently acting in the position.

The interim CEO meets every week or two with the Warden, Randy Grounds. There are no agendas for those meeting. The Warden participates in Medical Executive Leadership meetings and monthly Quality Management Meetings. Also, the Chief Deputy Warden and the Assistant Warden of Health Care attend the Quality Management Meetings. Relations between the medical program and custody appear to be very good. There do not appear to be any impediments to medical autonomy, and the Warden and staff work well with the medical program in addressing problems as they arise.

Human Resources, Staffing and Budget

Methodology: We interviewed facility health care leadership and human resources staff. We reviewed current and planned Acuity Based Staffing Realignment (ABSR) plans, vacancy and fill rates and job descriptions. We also reviewed the process for credentialing, peer review and annual performance evaluations.

Findings: Based on information given to us, budget position authority for medical positions (excluding psychiatric technicians and senior psychiatric technicians) consists of 215.3 positions. Of these, 38.9 (18%) are vacant. They have eight permanent intermittent employees (6 Certified Nursing Assistants and 2 pharmacy technicians) who are not on the budget authority. They also utilize 31 FTEs of registry staff (1 custodian, 6 CNAs, 9 RNs, 3 pharmacy technicians, 3 pharmacists and 9 LVNs). Under the Acuity Based Staffing Realignment plan the institution gained 32.7 positions. Among the increases in positions are 20 pharmacy positions, 2 physician positions, and 10 licensed vocational nurse positions. Every employee has an annual performance review. New employees have evaluations within the first year of employment. For physicians, there is no evidence of probationary evaluations for the 2010 year.

Two physicians have been added to the physician staff based on the Acuity Based Staffing Realignment plan. This will create a staff of 10 physicians. Currently there are 9 providers on staff, 8 physicians and 1 mid-level provider. Of the 2 new physician positions, one was recently filled and one remains vacant. These positions exclude the CME and Chief Physician positions. Of the eight working physicians, 5 are currently under some type of supervision. One physician is required to have all of his charts reviewed and 4 require 10% of their charts to be reviewed. One of the physicians also has a restriction of privileges.

Staff receives training on policies and procedures from supervisory staff but there is no standardized orientation program except for nursing. Nursing does have a nurse instructor who provides training to staff. Nursing has a separate policy and procedure manual related to Correctional Treatment Center (CTC) care and all nursing staff is trained on nursing policy and procedure. This is done at new employee orientation. The nursing orientation was started in

2011 after California Department of Health auditors of the CTC found that nurses were not given training on the nursing procedures in the CTC. Additionally, health care staff receives annual training from custody staff. The SVSP providers also take part in Central Office webinars.

Credentialing and Peer Review

As with other facilities, credentialing of physicians is performed centrally. When there is a problem identified related to a physician candidate's license status or National Practitioner Data Bank report, a Central Office executive must approve the candidate before sending the candidate on to the local hiring authority. In 2010, a physician candidate at SVSP had previously lost his license in New York for negligence and incompetence. He subsequently enrolled in a residency program in another state and obtained Board Certification in Family Medicine and subsequently had his medical license in New York re-instated. After reinstatement of his license, he remained on probation until two years before application to SVSP. There is no record in the SVSP credential file that this physician had any senior level review prior to hiring, even though CCHCS policy[5] requires Central Office review. Whether the prior license sanctions were considered in review of his credentials is not clear from the credential file at SVSP, and the candidate was hired before any of the current executives took their positions. This physician is now problematic and demonstrating some of the same clinical types of mistakes as were evidenced when he lost his license. He has been working at SVSP for two years. There is a current procedure[6] for proctoring and mentoring all physicians, which includes four clinical reviews during the first six months of practice concluding with a final probationary review. However, this procedure was put into effect five months after this physician started at SVSP. Nevertheless, until 2012, there is no evidence in the credential file that any clinical review of this physician's performance has taken place despite his prior history of license issues. This physician is now under monitoring. Since our visit, we have been informed that the physician has moved to the SVPP to provide medical care to psychiatric patients.

Five of 8 physicians at SVSP are under some form of monitoring, and 1 physician has modification of privileges. We therefore reviewed peer review procedures to assess the effectiveness of peer review and modification or revocation of clinical privileges. In 2008, the Federal Court issued the Order: Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency.[7] This established a process for suspension, revocation, or restriction of clinical privileges and described steps by which CCHCS could take administrative

[5] Volume 1, Chapter 9, Credentialing: Licensure, Certification and National Practitioner Data Bank Query, Inmate Medical Services Policies & Procedures, California Correctional Health Care Services as found on the website http://www.cphcs.ca.gov/imspp.aspx

[6] Volume 3, Chapter 4B, Primary Care Provider Mentoring- Proctoring Program and Clinical Performance Appraisal Process Procedure, Inmate Medical Services Policies & Procedures, California Correctional Health Care Services as found on the website http://www.cphcs.ca.gov/imspp.aspx

[7] Plata v. Schwarzenegger, No. C01-1351 TEH, Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency.

personnel action against a physician who had modification or loss of clinical privileges. This process was codified in procedures[8] pursuant to the 2008 Court order.

Title 22 has requirements for credentialing, privileging and physician discipline governing licensed facilities (General Acute Care Hospitals and Correctional Treatment Centers). Title 22 requires an Organized Medical Staff for a licensed General Acute Care Hospital (GACH) and allows but does not require an Organized Medical Staff for a Correctional Treatment Center (CTC). CCHCS has not developed policy to clarify the credentialing, privileging and physician discipline requirements of Title 22 with respect to the 2008 Court Order on Physician Clinical Competency. The Title 22 requirements for GACH facilities create ambiguity with respect with the 2008 Court Order and may contradict the Court Order. The Title 22 requirements for CTCs, however, can be modified to accommodate the Court Order.

CCHCS statewide policy[9] describing how to accommodate Title 22 requirements is outdated and has not been modified since the establishment of the Receiver. Policy[10] at SVSP regarding CTC physician privileging procedures was modified in December 2012, but still refers to organizational structures that pre-date the Receiver and permits an Organized Medical Staff to have authority to perform peer review and to recommend hiring and disciplinary action for physicians. These SVSP policies describe an organizational structure that is no longer in place and the SVSP CTC policy describes a means of physician credentialing, peer review, and physician discipline through an Organized Medical Staff that is inconsistent with current Court-ordered policies and procedures. The SVSP CTC policies also describe an organizational structure, including a Governing Body structure that has not existed since the establishment of the Receiver. This has resulted in ambiguities and confusion at SVSP with respect to managing substandard physician practice. At SVSP, specifically, the CTC policy contradicts statewide peer review procedures.

Title 22 creates ambiguities for institutions with a GACH because according to Title 22, GACHs must have an Organized Medical Staff that is responsible for peer review, discipline and recommending credentials. However, for Correctional Treatment Centers, Title 22 does permit the Governing Body to consist of a single individual, and permits the Medical Director to establish a system of peer review and to delineate credentials for licensed professionals; thus, an Organized Medical Staff is not required. Ostensibly, this would permit the CME to use existing CCHCS credentialing and peer review policy for the CTC. However, changes to the policy to reflect giving the CEO authority to act as the Governing Body and the CME authority to act as the Medical Director of the CTC with respect to peer review and credentialing were not officially in place at SVSP at the time of our visit and does not exist in state wide policies.

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[8] Plata Physician Professional Clinical Practice Review, Hearing and Privileging Procedures: Pursuant to Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency, July 9, 2008 *Plata, et al. v. Arnold Schwarzenegger, et al.* Federal Court Case No C01-1351, published September 2, 2008.

[9] Chapter 1, Administrative Overview, California Correctional Health Care Services Policies and Procedures.

[10] Salinas Valley State Prison, Correctional Treatment Center, Administration and Physician Services: Policy 1000.

Instead, SVSP kept old policy and even revised it in December 2012. This policy is problematic because it stipulates that the CTC peer review, credentialing, recommendations for hiring and recommendations for physician discipline are under authority of the Organized Medical Staff. As noted above, this is problematic because the Organized Medical Staff does not meet regularly. In addition, over the last two years, the Chief of Staff of the Organized Medical Staff has been under monitoring and it was evident to the CEO that there was a problem with the existing policy of having a physician under monitoring in charge of recommending physicians for credentials and responsible for overseeing the disciplinary process.

The ambiguity between peer review based on the 2008 Court order and Title 22 requirements at SVSP was highlighted when the California Department of Public Health (CDPH) performed an audit of the CTC unit at SVSP in February 2011. Among the more than 40 deficiency citations, the CDPH cited SVSP for failure of the Medical Director to develop a peer review process, failure to perform peer review, failure to ensure that licensed professionals undergo peer proctoring prior to obtaining privileges and failure to properly approve clinical privileges. Since CCHCS had an existing peer review process in place at that time governed by a policy based on Court Order, this should not have been an issue. However, the CDPH was evaluating the institution on the basis of the institution's existing policy on credentialing and peer review, which established a different process from that mandated by the 2008 Court ordered procedures. In any event, this peer review was not taking place because the Organized Medical Staff was not performing its duties.

The SVSP corrective action response to the CDPH was that they were going to ensure that the existing defective policy was carried out. They did not invoke a new model utilizing the 2008 Federal Court Order. In part, this was complicated by the fact that SVSP's CTC license does not apply only to SVSP's CTC, but also to the SVPP. This DSH inpatient unit utilizes the CTC license of SVSP to satisfy its requirements for licensing under California Title 22 regulations. This adds to the ambiguity of how to satisfy Title 22 requirements for peer review, credentialing and physician discipline because physician staff at the DSH facility are not under authority of CCHCS and the Federal Court Order of 2008.

The current contract[11] with the physician's union also affects this matter. For those facilities where there is an Organized Medical Staff, this contract requires the facility to have by-laws, and the Organized Medical Staff must form a committee to perform peer review. Peer review recommendations of the Organized Medical Staff result in recommendations for discipline. By having a policy establishing an Organized Medical Staff, SVSP is required by the existing union contract to have a peer review process that contradicts existing peer review and physician

[11] Agreement between State of California and Union of American Physicians and Dentists (UAPD) covering Bargaining Unit 16 Physicians Dentists and Podiatrists Effective July 1, 2010 through July 1, 2012. [The contract expired in 2012 but is the current contract?]

disciplinary procedures for physicians who work in the CTC as established by the Federal Court order of 2008.

SVSP leadership did not know how to apply Title 22 CTC license requirements under an arrangement where non-CCHCS physicians were practicing. As a practical matter, SVSP leadership told us both during and after our visit that they basically ignore their own recently revised December 2012 policy and that they are working around the policy until a solution is developed. Approximately three weeks after our visit, we were told that the CEO voided the SVSP CTC Policy 1000, Administration and Physician Services.

Central Office staff we interviewed were knowledgeable about the Court-ordered procedures for physician privileging and discipline, while SVSP management was not. Several physicians at SVSP who were alleged to have failed to perform consistent with an acceptable standard of care were referred to the Office of Internal Affairs (OIA) for investigation. It was SVSP leadership's belief that they were to refer physician misconduct and failure to perform at an acceptable standard of care to the OIA. The Court-ordered procedure requires referral of these cases to PPEC. This misunderstanding should be corrected by dissemination of the 2008 Court-ordered procedures to all leadership staff and integration of these procedures into existing CCHCS policy.

Given these misunderstandings, we doubt SVSP performs effective peer review and privilege modification. In addition, there have been four different CMEs at SVSP over the last four years. According to central office staff, each has approached peer review and revocation of privileges in a different manner. The current CME is not aware of the Court-ordered procedures. As a result, monitoring and peer review have not been either consistent or standardized.

The only existing CCHCS peer review policy[12] disseminated on the CCHCS Inmate Medical Services Policies and Procedures website consists of routine probation and annual peer review that the Chief Medical Executive performs. This policy describes the eUHR Clinical Appraisal (UCA). This is a review of a physician performed by either the CME or Central Office staff four times during a physician's probationary period followed by an annual review.

Other types of performance evaluations currently performed by CCHCS are not described in policy or procedure. A Clinical Performance Appraisal (CPA) is a review that is conducted by the CME or Central Office staff when, in their opinion, an additional review for the provider needs to occur. This can be the result of a practice pattern or a sentinel event. A Pattern of Practice (POP) is a review directed by the statewide PPEC and performed by Central Office staff based on a performance issue identified from a sentinel event or during a Central Office death review. Common to each of these reviews is a random selection of between 10-30 patient records. In addition to these reviews, either the Central Office or the CME can require a physician to

[12] Volume 3 Quality Management, Chapter 4B PCP Mentoring-Proctoring Program and Clinical Performance Appraisal Process Procedure; Inmate Medical Services Policies and Procedures found at http://www.cphcs.ca.gov/imspp.aspx

undergo monitoring. Such monitoring is documented in a report called a Monitoring Plan Report. Because the POP and monitoring plans are not delineated in policy or procedure, it was not clear to us how they are to be used.

According to the 2008 Court order, substandard clinical practices and clinical misconduct are to be referred to the Professional Practice Executive Committee (PPEC) for investigation. This investigation can result in modification of privileges which can result in loss of employment. PPEC can recommend remedial action, censure, modification or restriction of privileges, suspension of privileges, or revocation of privileges. Five physicians at SVSP are under monitoring; however, the OIA is currently investigating 2 physicians for disciplinary purposes for the same issue for which PPEC instituted monitoring. We could not determine why the OIA was investigating substandard clinical care; moreover, by CDCR policy, OIA investigations can take up to 3 years for non-custody staff. These issues should be referred to PPEC only.

With respect to peer review reports, all UCA, CPA, POP and Monitoring Plan Reports are kept on file in Central Office. It is the expectation of Dr. Steven Ritter, Assistant Statewide Chief Medical Executive, that each institution would maintain a copy of all documents for their reference. This is not the case at SVSP, where no documents are kept on file. Transmission of these reports is via email to the provider and CME. The only record of these documents at SVSP is the emails to the current CME that she has maintained electronically. However, any documents produced prior to her beginning her tenure one year ago were unavailable. If she were to leave, there would be no on-site record of monitoring or peer review for any physicians.

The extent of peer review documents the CME possessed were provided to us. We were provided with 2 annual physician UCA reviews from the prior CPS dating from late 2012 and 2 annual physician UCA reviews also from 2012. Another UCA was performed by Central Office in 2013. Thus, based on information provided to us, there have been only five annual required reviews performed since late 2012 for the eight working physicians, even though every physician is to have an annual UCA. Although five physicians are under some type of monitoring, over the past year Clinical Performance Appraisals (CPA) were available for only three physicians. Two physicians had three CPA reviews performed and the other physician had one CPA performed. There were Monitoring Plan Reports for two of the five physicians under monitoring. One of the physicians had two monitoring reports. For one of the physicians under monitoring, there were no reports. The current CME thus does not have the entire history of peer review of each of the physicians under her supervision and, therefore, effective monitoring is not occurring.

Tracking whether peer review has occurred was extremely difficult based on files at SVSP. Therefore, we went to PPEC offices in Sacramento to review files of SVSP physicians. These files were not in good order. Referrals to PPEC were not always in writing and information was not maintained in chronological order. There was no documentation of the danger determinations on file as required by the Court-ordered procedure. Peer review investigation reports are to

contain the reviewer's findings, conclusions, and recommendations but these were not consistently in the files. Written notices were not consistently on file so it was not possible to determine the chronology of decisions of PPEC. Written formal hearing decisions and the basis for those decisions was not consistently available. The condition of peer review files in PPEC offices made it impossible to determine the effectiveness of PPEC efforts.

The UCA and CPA reviews that were available on file in the PPEC office are based on random chart selections which may not include high-risk patients. A test of a physician's skill is best tested on a complicated patient. When this is not done, clinical reasoning and skill may not be adequately evaluated. Selection of random records likely results in uncomplicated, low risk patients being reviewed, making medical judgment errors appear harmless or less serious. Random record selection does not lend itself to evaluating the provider's ability to provide adequate care to patients with serious medical conditions.

There may also be varying interpretations of physician practice in determining whether harm has occurred, and there may be a reluctance to identify harmful practice due to the implications to the physician. We note one such case[13] in which a patient returned from Stanford Hospital diagnosed with endocarditis affecting a mechanical mitral heart valve. This patient will also be reviewed later in this report in the discussion of death reviews. This patient had a life-threatening illness and was discharged from Stanford Hospital with orders for intravenous antibiotics for an infection of his heart valve and warfarin for anticoagulation because he had a mechanical heart valve. The Stanford physicians asked that antibiotics not be stopped unless they were consulted, and they also recommended follow-up echocardiogram and cardiology follow-up. None of these recommendations was followed. The patient initially refused antibiotics at SVSP, so a physician on the SVSP CTC started oral antibiotics, which would not be effective for endocarditis. The physician did not consult with an infectious disease physician or with the Stanford physicians to determine if the oral antibiotics would have been a reasonable alternative and to determine the correct choice of an antibiotic. The patient was also sent to general population with routine follow-up despite having an inadequately treated life-threatening condition. The patient was then seen by a physician (who is on monitoring) because his INR was elevated[14] (INR 4.5, target=< 2.5-3.5). The physician stopped the warfarin instead of holding it and restarting at a lower dose. This error could have resulted in death but was noted by the mortality reviewers as a departure of care not meriting peer review. This physician also failed to identify that the patient had active endocarditis and was on ineffective therapy. Another physician (who is also on monitoring) saw this patient numerous times, yet he failed to identify that the patient had active endocarditis and failed to obtain tests to ascertain whether the oral antibiotics had been effective. Neither physician ordered an echocardiogram, blood cultures, cardiology appointment, consulted with an Infectious Disease expert or continued anticoagulation therapy. We deem these multiple physician encounters as not

[13] Mortality Review Patient #2.

[14] INR is a blood test used to determine whether a patient is being appropriately anti-coagulated.

consistent with a standard of care expected of a reasonable and prudent practitioner acting in the same or similar circumstances. The mortality review did not believe an error had occurred or cited only a simple departure from the standard of care. This patient ultimately died of complications of his endocarditis. Based on the peer review material available to us, none of these episodes of care resulted in a referral to PPEC.

Another case[15] involved a patient who was seen emergently by a nurse on 11/30/11 describing "unbearable" back pain starting a week previous. The patient described his pain as 10 of 10 in severity and could not walk. A nurse called a physician who gave an order for a muscle relaxant with a three-day follow-up. There was no documented history by the physician. The follow-up never occurred. Six days later, the patient placed a 7362 health request because of back pain causing his leg to "shake." He asked to see a physician. The patient was transferred in a wheelchair to see a nurse and the nurse evaluated the patient about 2 p.m. on a Monday. The nurse consulted a physician. This physician took no history and gave no recommendations except for a routine follow-up.

The following day the patient was seen emergently in the TTA with a complaint that he could not move his legs. A nurse documented that the patient could not urinate. Although the patient said he could not move his legs, the nurse documented that the patient could move his leg from left to right. A physician was called and ordered a straight catheter to be placed in his bladder, which produced a liter of urine, and the patient was sent back to housing without sending the patient for a physician examination.

The following day at noon, the patient was seen emergently for severe back pain and fecal and urinary incontinence. He had a 101.5° F. fever. The nurse documented that a physician was present and examined the patient and sent the patient to a hospital where cauda equina[16] syndrome was diagnosed.

Two of the three physicians involved in this episode were under investigation by the Office of Internal Affairs (OIA) for this incident. We received conflicting statements from various executive staff regarding whether PPEC had conducted a review. We could not initially ascertain what actually happened because there was no documentation of this incident in the credential file of the two physicians under investigation, and none of the executives at SVSP knew the resolution of the matter, even though both physicians were still employed at the facility. After our visit, we were told that PPEC had reviewed these physicians. They received counseling and education. Subsequent physician care was evaluated by chart review and monitoring for a period of time. We reviewed PPEC files at CCHCS and found that the files were disorganized and appeared to be missing documents. The Peer Review Subcommittee reviewed one of the physicians and closed the case without action, but documentation of their

[15] Hospital Review Patient #12..

[16] Cauda equina is an impingement of the spinal cord often by cancer or infection that causes a loss of nerve function below the area of spinal cord impingement.

reasoning was not evident in the file. The peer review file of the 2nd physician documented that the physician was initially taken off duty on the basis that he was dangerous to patients. A PPEC designee then made a decision that the physician was not a danger, but the rationale for this was not adequately documented it the file. PPEC did review this physician through the Peer Review Subcommittee and developed a plan for education and monitoring for this physician. Both of these physicians still had open cases with the OIA until very recently.

We note that three physicians at SVSP were referred to PPEC for danger determinations. This is a request to remove clinical privileges of the physician because the physician is considered a danger to patients. In none of the 3 cases did PPEC determine that the physician was a danger to patients. However, the reports of these danger determinations were not in the files and we could not determine the basis for the determinations. One of the physicians was referred for a danger determination for a reason similar to cases for which he had previously lost his license. The danger determination report was not in the file.

In summary, we do not have confidence that the peer review process at SVSP is effective for the following reasons:

- The substantial number of cases of substandard care we report that have not resulted in peer review.
- The lack of UCA monitoring based on CCHCS requirements.
- Lack of knowledge of SVSP leadership of Court-ordered physician peer review, physician discipline, and privileging procedures.
- Lack of existing SVSP local operating procedures consistent with the Court-ordered physician discipline and privileging procedures.
- Lack of effective tracking of peer review at PPEC offices.
- Lack of tracking at SVSP of physician peer review.
- Confusion of SVSP management regarding the role of the OIA with respect to physician discipline for clinical matters.

Disciplinary Process

As with other facilities, SVSP has difficulty in disciplining staff. Furthermore, as noted below, it is difficult to obtain accurate information related to disciplinary cases. Based on information given to us during the week of our review, we were told that there were 19 disciplinary cases pending. The range these cases started was from October 2010 to February 2013. One individual had two disciplinary actions. Of the 18 employees, two have been redirected for periods of over 2.5 years. One is an RN and the other is an LVN. The RN is being disciplined for narcotic diversion and also for using a contaminated needle on a patient. She was redirected to the mailroom. The LVN violated medication distribution policy in March 2011 and the

disciplinary process was approved by the hiring authority in October 2012. She was redirected to the mailroom as well. These redirections effectively reduce the staff by two nurse positions for as long as the disciplinary process takes. One of the 19 cases is settled. The remaining 18 cases have been pending on average for 10.6 months, with a range of 2 months to 27 months. This is a very long time to enact discipline.

There are two disciplinary processes involving physicians for clinical issues which have been ongoing for 17 months. Although the reason for discipline for these physicians was clinical, we were initially told that they were being investigated through the personnel process rather than the PPEC process. However, about a month after our visit, we received information that PPEC had indeed evaluated these physicians. The 2008 Court order requires a disciplinary process for clinical competency to be directed by PPEC. In this case, PPEC did review the case, but the physicians were nevertheless disciplined through the normal OIA investigative process.

On June 29, almost a month after our review and after attempts to uncover the disposition of the two physician OIA investigations, we received different information related to discipline confirming that there were only 16 open cases open an average of 11 months and ranging from 3 to 24 months. The Employee Relations Officer (ERO) indicated that she removed two physician cases that had been open for 17 months. The two physician cases had apparently been referred to PPEC, resulting in counseling and education for 1 physician and closure with no action for the other physician. In both cases, the ERO considered the cases closed but had not officially completed paperwork.

Management could improve its current knowledge of significant discipline by making sure they are up to date on all discipline cases.

We continue to recommend that the CDCR progressive discipline process be amended so that performance expectations are consistent with professional practice standards and not with performance expectations of custody staff. We also recommend that CCHCS Central Office and institutional leadership be responsible for progressive discipline of all health care employees.

Health Care Budget

In fiscal year 2010-11, SVSP had an initial budget allotment of approximately $22.28 million, a final budget allotment of approximately $42.35 million and expenditures of $41.08 million. In fiscal year 2011-12, SVSP had an initial budget allotment of approximately $37.49 million, a final allotment of approximately $45.23 million and expenditures of $43.75. The appropriation for fiscal year 2013 is approximately $38.80 million. This is a difference between initial allotment and expenditures of approximately $18.8 million for 2010-2011 and $6.26 million in 2011-2012. The initial appropriation for fiscal year 2013 is $5.45 million less than the previous year's expenditures. As with other facilities, the budget allotment does not match needed expenditures. The expenditures in excess of allotment were provided through the Receivership. A budget process that is not based upon real operating costs does not assure that future

budgets will be sufficient to provide adequate health care. We have the same concerns regarding the budget allotment as expressed in prior reports.

As with other facilities, the business software is underutilized because it does not satisfy the business needs of health care management. Management does not have the tools necessary to manage their budget.

Health Care Operations, Clinic Space and Sanitation

Methodology: We toured central and housing medical clinics, the Correctional Treatment Center (CTC) and administrative and ancillary support areas. In addition, we interviewed staff involved in health care operations.

Findings: The SVSP facility has medical clinic space in each of the A, B, C and D yards, as well as a TTA and a CTC.

The CTC unit was subject of a very negative audit by the California Department of Health on 2/18/11. This audit demonstrated deficiencies in most areas of service, including sanitation and maintenance on this unit. There still is clutter on the unit, especially with equipment being stored in the halls. However, since that audit, the program has worked on sanitation on this unit and, during our inspection, patient rooms, showers, and halls were clean and sanitized.

The same cannot be said for the medical clinics in the yards and in the TTA. The TTA consists of three rooms. One room is the main clinic examination room, and two other rooms serve as backup rooms. There were excessive supplies in all rooms, resulting in clutter. In one room, hundreds of boxes of gloves were present, which staff said was because the rooms were used to store emergency supplies in the event of a disaster. However, the number of gloves exceeded the amount that would be needed given the numbers of employees working at the prison. In the main examination room, the physician desk was next to two nursing desks. Officers generally stood in the entryway. The patient would sit on a gurney so that the interview between the patient and the physician was not private but was conducted in front of whatever nursing personnel were present as well as in front of officers. This clinic space was not a space in which private interviews could readily be conducted. In addition, a physician was observed eating in the TTA, which is not compliant with OSHA regulations.

The A clinic was extremely cluttered, filthy and generally unacceptable for clinic space. Triage is performed in the hallway. There were three examination rooms, one of which had been originally intended as a closet. Nothing in this clinic appeared to be in a standardized location. Supplies and equipment were extremely disorderly. The medication room had medicine and supplies stored on the floor, on counters and in drawers that were open and used as shelving. This room was not sanitary. A microwave and food were present in the room.

The B clinic was also cluttered and not well-sanitized. Nurses triaged patients in the hall. The arrangement of equipment in the clinic examination rooms in all yards was not standardized

and did not compare favorably with typical examination rooms in any civilian sector physician office.

The C clinic was equally inadequate. This clinic had one physician office which was neat, orderly and clean. We were told that this was due to the individual efforts of persons working in this room. Another physician examination room did not have a chair for the patient to sit on. In general, every examination room was arranged differently with different arrangements of supplies, equipment and furnishings. All office and examination space needs to be organized in a standardized manner and maintained by medical administration so that clinical staff has an appropriate work environment.

The D clinic had similar problems with sanitation, supplies, equipment and space. This clinic had several rooms that were extremely cluttered, and a nurse explained that there was no space to store supplies. In one nurse examination room, there was barely space to work. Excessive supplies were present, which reduced useable space and impaired the ability of staff to perform their assignments. In one examination room, two brand new EKG machines in the original boxes were found on the floor of the room. A nurse explained that she did not know how long these had been present but that they had been in that location for a long time. Apparently, these were intended for the segregation medical clinic, but given that the equipment could not be secured because custody staff accesses the clinic, the EKG machines were kept in this examination room. These findings indicate lack of administrative control over sanitation, supply chain, and control of space and equipment.

Sanitation in the yard clinics is unacceptable. While there is one employee and a second contract custodian who clean the CTC unit, the yard clinics are cleaned by inmate porters. There is an operational procedure[17] describing daily cleaning procedures, but we were not provided with a cleaning schedule. Cleaning does not occur during lock downs in the yard clinics and it does not appear, based on the presentation of the clinics during our tour, that cleaning, even when it does occur, is effective. This is a systemic issue that has been found at every facility.

No Periodic Automatic Replenishment (PAR) system is in place. There is a large warehouse in B facility, which is dedicated to medical supplies. It is about 3000 square feet. It is orderly and clean. However, supply staff could not confirm that there is an inventory of supplies in the warehouse, and they could not tell us the inventory they had. Supply orders are not based upon numerical tracking but typically based on best guesses of supply needs and by looking at supplies on shelves. The storeroom staff works at both the CTF and SVSP facilities and not full time at SVSP. Any employee can order from the supply room and, as a practical matter, supply distribution is dependent on employees maintaining supplies in their area. This process is not standardized and, as a result, each area we inspected had excessive and disorganized supplies.

[17] Operational Procedure #244, Clinical Cleanliness.

In summary, for operational areas, the deficiencies we noted demonstrate a lack of administrative oversight and effective management.

Policies and Procedures

Methodology: We interviewed health care leadership and staff and reviewed selected statewide and local policies and procedures to determine whether they were periodically reviewed and whether updated local policy was consistent with statewide policies.

Findings: CCHCS does not have a procedure for policy development. As a result, final approval authority of policies apparently is left up to each site to determine. The 36 Local Operating Procedures contain procedures for all major areas of service and are well-written. However, all of the SVSP local operating procedures identify the Warden as final authority for approval for all procedures (including clinical ones) instead of the CEO or CME. This is not consistent with the table of organization in terms of lines of authority, and appears to violate the principle of medical autonomy within correctional facilities. We support collaboration with custody and other disciplines to develop health care policy and procedures; however, the medical authority must be the ultimate authority regarding clinical matters, not the Warden. Some of the policies the Warden gives final approval for include: chronic disease management, preventive clinical services, medical evaluations after use of force, health record documentation, urgent and emergent responses and quality management. This level of control of the medical program as described in policy by the Warden is inappropriate. Most other facilities require approval of the Quality Improvement Committee with final authority resting with either the CEO or CME.[18]

There are a large number of policies and procedures at this facility. There are 16 CTC policies and 36 local operating policies and procedures. Each of the 16 CTC policies is actually a policy manual. In total, the 16 CTC "policies" actually contain 455 CTC policies. If mental health, dental and custody policies are not included, there are 332 policies. The 332 medical CTC policies and 36 local operating procedures total 368 policies. This is a large number of policies to manage. All of the policies have been signed as reviewed within the last year. However, we note that many policies recently signed or documented as recently reviewed, particularly in the CTC policy section, were outdated and referred to organizational arrangements that predated the Receivership and therefore did not apply to the current table of organization.

As noted earlier in the report, one example of a policy that is outdated is the CTC Administration and Physician Services Policy 1000, which includes the physician bylaws and describes credentialing, privileging and discipline of physicians. The policy defines a Governing Body which pre-dates the Receivership; yet this policy was reviewed December of 2012. Also, this policy contradicts peer review and physician disciplinary procedures stipulated in the 2008 Court order on physician clinical competency. When we brought up problems with this policy to

[18] Corcoran required joint approval by the Warden and the Chief Executive Officer, which is a reasonable alternative, but SVSP is the first CDCR facility we have visited in which final approval of all medical policies and procedures rests with the Warden.

local leadership, they indicated that they worked around the policy or ignored it. Three weeks after our tour concluded, we were told that the policy was declared void by the CEO.

As noted above, the CTC license covers SVPP. There is no mention of this in any of the CTC policies and procedures. This arrangement can cause significant difficulty in terms of medical records, management of credentialing and monitoring of medical staff, and collaboration and integration of two separate agencies. Yet, these arrangements are not mentioned at all in policy. We do not believe that it is wise or appropriate for these two separate facilities to be covered under a single CTC license. But if that is to occur, the arrangements for how this is to occur and the relationships between these facilities must be described in the policies and procedures for the CTC.

We were provided with procedures for 16 areas of service in the CTC including laboratory, pharmacy, plant operations, radiology, food and nutrition, personnel services, mental health, dental services, nursing services, standby emergency, infection control, nursing administrative, administrative and physicians, environmental services and physical therapy. The CTC procedures were written by individual departments, and there is no collaboration to ensure that they are internally consistent with one another. The problem with this is that the procedures may not serve the needs of the organization, only the department. We did not visit the SVPP to evaluate whether the CTC policies accurately describe practices at that facility.

We note several minor problems with CTC policies and procedures. Neither the CTC laboratory procedures nor the Diagnostic Test Results local operating procedure has a procedure for reporting critical values. Another example is that the CTC pharmacy procedures specifically state that Nursing and other departments are to review pharmacy procedures to ensure that pharmacy procedures do not conflict with their own procedures. This should not have to be stated. Policies should be internally consistent by virtue of stakeholder review prior to final approval of each policy. A system of development of procedures that permits each department to develop its own procedures fosters a silo mentality which is not in the best interests of the organization. There needs to be a process for unified policy and procedure development to which all stakeholders adhere to uniformly.

Having individual departments write their own policies also can create confusion organizationally. The pharmacy CTC procedure 6103 states that the PIC "is immediately responsible to the CME or CEO." This is confusing. One cannot report to two individuals simultaneously. This is not a clear reporting relationship and is not consistent with the table of organization which describes the PIC reporting to the CEO.

The Nursing Services procedures for the CTC are really a nursing instructional manual, including 81 procedures with items such as how to apply an ACE bandage, how to weigh a patient, how to manage side rails of a bed or how to collect a urine specimen. These may be useful to place in a document for instructional purposes, but it may be more effective to describe these instructional items as a manual and not as policy. Inclusion in the policy gives the impression

that this manual is actually a policy. When the California Department of Public Health (CDPH) audited the facility in 2011, one of their findings was that the nursing policies were not recently reviewed, were unavailable on the unit, and that staff were unaware of the policies and had not received training on them. If this manual of nursing practice is described as a policy, it has regulatory implications as happened in the CDPH audit.

Intrasystem Transfer

Methodology: We interviewed facility health care leadership and staff involved in intrasystem transfer and reviewed tracking logs and 15 health records of patients with chronic diseases.

Findings: We found that sending and receiving facility nurses complete intrasystem transfer forms in a timely manner. However, we found significant issues related to continuity of care. In addition, our review showed that following arrival at SVSP, medical care of patients was fragmented and of poor quality. Our findings are not consistent with the OIG Cycle 3 report score of 88.3%.

In two records, we identified problems with the sending facility. In one case, a diabetic patient transferred from CTF and did not receive his morning insulin prior to transfer. Upon his arrival at SVSP, his blood sugar was very elevated (approximately 400 mg/dL).[19] In another case, a patient with an intractable seizure disorder transferred from Pelican Bay State Prison (PBSP) to Kern Valley State Prison (KVSP) and then to SVSP. At KVSP, the patient had a seizure at approximately 3:30 am, was treated in the Triage and Treatment Area (TTA), and then transferred to SVSP later that day. En route, the patient had another seizure. Upon arrival at SVSP, staff sent the patient directly to the local hospital. The patient was later admitted to Stanford University Hospital with status epilepticus.[20] This patient should not have been placed on the bus having just had a seizure.[21]

SVSP nurses complete a 7277 health screening form for each new arrival, noting whether chronic disease and/or mental health medications transferred with the patient. Nurses did not consistently measure vital signs and weight for patients with chronic diseases[22] (e.g., hypertension, diabetes, etc.) per CCHCS policy[23] and as clinically indicated. For example, on 5/22/13, a patient with diabetes and heart failure transferred to SVSP and the nurse did not measure the patient's vital signs or weight. The nurse also did not document a timeframe for referral. One week later, the patient presented urgently with shortness of breath and weight gain, but no baseline weight was documented to evaluate weight gain since his arrival at the facility.[24]

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[19] Intrasystem Transfer/Sick Call Patient #2.
[20] Status epilepticus is a life-threatening condition in which the brain is in a state of persistent seizure.
[21] Intrasystem Transfer/Sick Call Patient #13.
[22] Intrasystem Transfer/Sick Call Patients #2, #4, #6, , #7, #9, #12, and #15.
[23] Health Care Transfer Process. CCHCS Inmate Medical Services Policies & Procedures (IMSP&P). Volume 4. Chapter 3.
[24] Intrasystem Transfer/Sick Call Patient #2.

A significant finding is that the pharmacy was renewing medication orders without review and signature by an SVSP medical provider. In almost all records we reviewed, we found medication reconciliation forms in which an unknown staff member checked the box to renew each medication, but the form lacked a signature by an authorized medical or mental health provider. In fact, the form was unsigned by any staff member, including whoever checked the boxes to renew each medication.[25] Staff faxed these forms to the pharmacy and each medication was automatically renewed for 30 days under the signature of the medical or mental health provider at the previous facility. Although transfer of an existing medication order would have been legal, this process changed the duration of an existing order, either extending or shortening it, without the authorization of the provider who wrote the order. We believe this practice is both dangerous and illegal. This is discussed further in the Pharmacy Services section of this report.

With respect to continuity of medications upon arrival at SVSP, May 2013 medication administration audit found that 21 of 28 (75%) of newly arriving patients received medications according to policy and procedure. For records that were noncompliant, barriers to compliance included staff shortages and medication refusals not being properly documented.

Nurses appropriately referred patients to a provider but did not always document a timeframe for referral, and, in some cases, the requested referral did not occur timely. In one case, on 6/3/13, a patient with diabetes, hypertension, epilepsy, and asthma was transferred to SVSP and upon arrival was identified as being suicidal. He was placed in the CTC on suicide watch, was briefly transferred to High Desert State Prison and then transferred back to SVSP. As of 7/17/13, an SVSP provider had not seen the patient for primary care management of his chronic diseases.[26]

We found that patients were usually seen within 30 days of arrival. The purposes of the initial visit are for the provider to become familiar with the patient's medical history, update the Problem List, and develop an initial plan of care. However, in several cases, we did not find that providers adequately reviewed the patient's medical history, other than to list their chronic diseases. We found the care provided at these initial visits to be episodic and cursory.

We also found cases that did not meet the standard of care. One example is a 53-year-old with a history of diabetes, coronary artery disease, valvular heart disease, and heart failure. One week following his arrival, at an initial visit, Dr. T. documented that he was short of breath (SOB) and gained 20 lbs. The patient was so short of breath he had difficulty speaking and tying his shoes. The provider noted that he had abnormal heart sounds, mild swelling of his ankles, and diagnosed him with exacerbated heart failure. The provider referred the patient to the TTA for immediate treatment. At the TTA, Dr. B. did not address the reason for the urgent referral of the patient. He documented that the patient had pain in his feet, recent changes in his

[25] Intrasystem Transfer/Sick Call Patients #1, #2, #3,# 4, #6, #7, #9, #11, #12, and #13.
[26] Intrasystem Transfer/Sick Call Patient #3.

medication, and "states breathing fast." Although Dr. B. noted the patient's cardiac history, he performed no review of systems (ROS) related to his heart disease and documented all physical findings as normal except neurological.[27] His diagnoses were anxiety and peripheral neuropathy, for which he started amitriptyline. He sent the patient back to the housing unit without addressing his heart failure.[28]

In another case, a 56-year-old patient transferred to SVSP on 1/14/13. His medical history included stroke with left-sided weakness and cerebral artery aneurysm. On 1/29/13 at 2:30 p.m., a registered nurse saw the patient, documenting that he had inspiratory rales (i.e., crackles) in all lung fields and had swelling of his left leg that was new for him. The nurse referred the patient directly to Dr. B., who documented that the patient was a new arrival. With respect to history, he noted that the patient "c/o (complained of) R (right) post (posterior) back pain with deep breath x 4 days, legs swelling x 1 mo (month). New to B Yard. Poor historian." The physician did not obtain any other history or perform a review of systems for any of his medical conditions. He documented the patient's pulmonary and cardiac examination as being normal except for having swelling of his legs. Although the patient had a stroke with left-sided weakness, the physician did not perform a neurological examination. Dr. B. made no reference to the nurse's abnormal pulmonary findings that generated the referral. He listed the patient's medical conditions and ordered labs, and planned to see him in one week.[29]

On 2/5/13, Dr. B. saw the patient again. He documented: "c/o pain in hands and legs, wants to continue methadone which expired 1/29/13. No indication for methadone. See 1/29/13 swelling in legs gone." This was the extent of the history. He did not address the patient's history of a stroke with left-sided weakness or other medical conditions that included hepatitis C, hyperlipidemia, seizure disorder, or hemorrhoids. He diagnosed the patient with osteoarthritis of his knees and CAD (coronary artery disease), which is not supported by documentation elsewhere in the record; it is unclear what the basis is for these diagnoses. The extent of the physical examination was to note that the patient had "B (?bilateral) hands *illegible* swelling." He did not perform a neurological examination, which was pertinent given the patient's history of stroke, left-sided weakness, and existing cerebral artery aneurysm.[30]

Another concern is that SVSP providers discontinue pain medication and chronos without evaluating or discussing the changes with the patient. Three examples are described below.

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[27] Dr. B did not describe the abnormal neurological findings, however.

[28] Intrasystem Transfer/Sick Call Patient #2.

[29] Intrasystem Transfer/Sick Call Patient #16.

[30] In April 2013, the patient would be admitted to Stanford University Hospital for evaluation of the right middle cerebral artery aneurysm. The physician documented the following neurological findings secondary to his previous stroke: "Alert and oriented x 3, left cranial nerve VI palsy, lateral nystagmus (horizontal oscillation of the eyes), left facial droop with forehead spared, left tongue deviation, left 4th and 5th digits in flexion, decreased touch sensation in left face, arms and legs, left pronator drift, and 4/5 left foot dorsiflexion, normal tone." These are all findings related to his previous stroke that would likely have been present at the time Dr. B. examined the patient.

- A 40-year-old with a history of carpal tunnel syndrome, degenerative joint disease, surgical repair of his left ankle, hypertension, chronic kidney disease and hyperlipidemia arrived at SVSP on 5/22/13. The patient had multiple chronos, including a wrist and ankle brace, ground floor and bottom bunk. On 6/17/13, the CPS rescinded all chronos without evaluating the patient or discussing the clinical rationale for discontinuing all his chronos.[31]

- A 44-year-old arrived in CDCR in 2008 and transferred from KVSP to SVSP on 5/13/13. His medical history included a motor vehicle accident (MVA) with paraplegia, seizure disorder, disseminated pulmonary coccidioidomycosis in 2005, and degenerative joint disease (DJD). On 5/28/13, a physician performed an assessment and increased the patient's gabapentin for pain management. On 6/20/13, another physician, without examining the patient, wrote an order to taper the patient off gabapentin when the current order expired on 9/26/13. There is no documentation that the physician discussed the plan with the patient.[32]

- A 32-year-old with a history of bilateral knee pain, congenital patellofemoral syndrome, and s/p arthroscopic repair of a torn left medial meniscus transferred to SVSP on 1/23/13. He was prescribed methadone for pain. On 1/28/13, the patient submitted a health request for chronic knee pain and a nurse referred the patient to a provider. The following day, without seeing the patient, Dr. B. wrote the following order: "Pharmacy taper off methadone" with no further instructions regarding the duration of the taper, whereupon the pharmacy implemented a taper of the medication. On 2/21/13, Dr. B. saw the patient for chronic knee pain and a request to renew his methadone. Dr. B did not document an examination of his knees but renewed his methadone.[33]

These cases are problematic for several reasons. It is inappropriate to change or discontinue medications or a treatment plan prior to performing a clinical evaluation and discussing changes with the patient. It is equally inappropriate to prescribe narcotics without a medical history and clinical findings that support the use of narcotics. Finally, we believe that the orders instructing the pharmacy to taper the methadone and gabapentin did not meet the requirements for a legal medication order (i.e., dosage, duration, etc.). This is described further in the Pharmacy Services section of this report.

[31] Intrasystem Transfer/Sick Call Patient #7.
[32] Intrasystem Transfer/Sick Call Patient #1.
[33] Intrasystem Transfer/Sick Call Patient #15.

Access to Care

Methodology: To evaluate access to care, we interviewed health care leadership and reviewed patient tracking and scheduling systems. We also reviewed 40 health services requests (CDCR Form 7362) in 13 records of patients with chronic diseases, including high-risk patients.

Health Care Appointment Scheduling

Findings: We did not find significant backlogs with nurse or provider appointments. However, the new MedSATS program has been recently rolled out across the system and is presenting challenges with respect to the efficiency of scheduling appointments. Moreover, reports produced by MedSATS do not provide staff the ability to easily track pending appointments, and it was particularly problematic for specialty services (See Specialty Services).

Nursing Sick Call (Face-to-Face Triage)

Findings: SVSP health care staff collects, triages and usually sees patients in a timely manner following submission of health service requests. This is consistent with the OIG Cycle 3 report score of 86.9%.

However, the SVSP Access Measure Audit Tool (AMAT) results for April 2013 show that nurses saw patients with symptoms in 100% of cases, but that provider referrals only occurred timely in 61% of cases.

Although nurses generally responded timely to patients with medical symptoms, responses to patients submitting medication refills and/or dental requests were not handled in a timely manner. We found cases in which the patient submitted multiple requests (3 or 4) because of a lack of response to the initial 7362. When nurses did see patients, the quality of the nursing assessments was variable. In some records, nurses did not obtain a history of the presenting complaint, perform any physical examination, or both.[34] A significant concern is that when nursing protocols call for over-the-counter acetaminophen, nurses provide the patient acetaminophen packaging that contains 100 tablets. This amount exceeds what is clinically appropriate for most patient conditions. In addition, it presents a risk that the patient will take an excessive amount and that could cause serious liver damage. As an example, in February 2013, an officer observed a mental health inmate who reported taking 100 tablets of acetaminophen. The patient was sent to the hospital for evaluation and no adverse outcome occurred, but the hospitalization might have been avoided if the patient was not given so many acetaminophen tablets.

Nurses appropriately referred patients to a provider. The most significant concern related to access to care was quality of provider evaluations and delays in care for routine and urgent

[34] Intrasystem Transfer/Sick Call Patients #4, #6, #11, #14, #15, #16.

consultations. Nursing leadership reported that relationships with custody were very good, but that physicians often limited the number of patients that they (the physicians) see.

Examples demonstrating issues with access to care are noted below.

- A 41-year-old arrived at CDCR in 2006 and transferred from COR to SVSP on 1/16/13. His medical history included diabetes, hypertension, myopathy, mood disorder, bilateral neck adenopathy and submandibular neck mass. On 1/21/13 and 1/23/13, the patient submitted 7362s requesting to have his pain medications renewed, stating that he had been taking it for three years. They were received and triaged on 1/23/13 and 1/24/13, respectively. On 1/24/13, the nurse saw the patient but did not take any history of the patient's pain (location, quality, intensity, alleviating and aggravating factors). The nurse did not conduct any physical assessment of the patient, or note labs. The nurse's diagnosed "alteration in comfort per patient statement" and referred the patient to the provider, who saw the patient on 1/28/13.[35]
    - On 3/27/13, the same patient submitted a 7362 complaining of right-sided facial and neck pain, and having a lump on his neck. On 3/28/13, the nurse saw the patient, noting that he was having sinus problems and his right ear was stuffy. The pain was 3 of 10 in severity. The patient was afebrile. The nurse examined the patient's ear but not his nose, throat or neck. The assessment was "alteration in breathing pattern related to sinus stuffiness." The nurse treated the patient symptomatically according to a protocol. The nurse did not perform an appropriate evaluation of the patient and did not make an appropriate referral.
    - On 4/4/13, the same patient submitted a 7362 complaining of neck pain and swelling that had been going on for over 10 days. On 4/6/13, the nurse saw the patient. He was afebrile. The nurse palpated a lymph node below his right ear. The nurse appropriately referred the patient to a provider. On 4/9/13, Dr. K. palpated an indurated, irregular swelling involving the upper half of his right neck. Her diagnosis was to rule out lymphadenitis/abscess/mass. On 4/11/13, a neck CT showed bilateral cervical adenopathy including a 3-4 cm neck mass; lymphoma and metastatic disease are considerations.
    - On 4/17/13, the patient submitted a 7362 complaining of painful swelling of his neck and skin complaints. On 4/19/13, at 0835, the nurse saw the patient, who reported the mass had increased in size. The nurse measured vital signs but did not inspect or palpate his neck. The nurse's assessment was health-seeking behavior and referred the patient to a provider in five days (4/22/13). This was not a timely referral given the patient's pain and increase in size of the mass.

[35] Intrasystem Transfer/Sick Call Patient #4.

- On 5/16/13 and 5/20/13, the patient submitted 7362s complaining of having swelling in his throat, making it painful to eat and swallow food, and ear pain. He also complained of painful headaches that continued all day. They were received and triaged on 5/17/13 and 5/20/13, respectively. On 5/20/13, the nurse saw the patient, noting that he was not seen the previous week due to a conflict. The nurse noted that the patient had a right-sided neck mass with swollen lymph nodes. His throat was red with swelling on both sides. The nurse's assessment was "alteration in nutrition R/T (related to) swallowing issues" and the plan was to follow up with the office technician (OT) to ensure follow up with the physician this week. This is not a timely referral given the patient's difficulty in swallowing and potential for infection. On 5/23/13, ENT saw the patient, recommending antibiotics x 3 weeks, and if not resolved, then performing an excisional tonsillectomy and biopsy of right neck node, direct laryngoscopy with biopsy. On 6/21/13, the patient underwent bilateral tonsillectomy with pathology reports pending. As of 7/28/13, the pathology report is not in his eUHR.[36]

- A 40-year-old patient with hypertension, chronic kidney disease, hyperlipidemia, degenerative joint disease and GERD transferred to SVSP on 5/22/13. On 6/17/13, the patient submitted a 7362 stating that he needed to see the physician to renew his medication, request a mattress and pillow per chrono, and that he was a new arrival. The same day, the Chief P&S discontinued all the patient's chronos. We found no documentation that the Chief P&S evaluated and discussed the changes with the patient. A nurse did not see the patient.[37]

  - On 7/10/13, the patient submitted a 7362 stating that he was not aware that all his chronos had been rescinded. He requested an appointment with the provider. On 7/12/13, a nurse documented that the patient would be referred to the provider, but as of 7/28/13, there is no documentation in the eUHR to show that a provider saw the patient.

- This 49-year-old arrived in CDCR in 1983 and transferred from KVSP to SVSP on 5/7/13. His medical history included hypertension, CVA x 2 with residual left sided-hemiplegia, asthma, depression, and ORIF knee. Prior to transfer, in March 2013 the patient was hospitalized twice for headache and fever as high as 103°F. The patient underwent an extensive workup for bacterial endocarditis, meningitis, cocci and sepsis but was not tested for HIV infection. Upon arrival, the patient had an abscess of his left buttocks and requested dressing changes, stating that it was still draining and required 2-3 dressing

[36] On 7/19/13, the patient transferred to RJD. As of 7/28/13, the pathology report is not in his eUHR, and on 7/22/13, a release of information was written to obtain the report.
[37] Intrasystem Transfer/Sick Call Patient #7.

changes per day. On 5/14/13, Dr. K. saw the patient and questioned whether the patient had a fistulous tract and referred the patient to general surgery.[38]

- On 5/20/13, a nurse saw the patient for a dressing change, noting that the patient had completed his antibiotics and now had a 1 cm abscess forming above his anus. The nurse received an order for Bactrim x 5 days and follow-up with a PCP in 5 days. The following day, he presented for dressing change and reported having headache, nausea, vomiting, and rash. He also reported diaphoresis, chills and possible fever. The nurse contacted Dr. M., who stopped the Bactrim and ordered wound culture, and follow-up with provider in four days. A complete blood count obtained the same day showed a high white blood cell count, suggesting systemic infection.[39]

- On 5/24/13, Dr. M. saw the patient for a chronic disease visit and follow up of his rectal fistula. With respect to his fistula, he documented that the fistula appears to be healing but the patient reports that it still swells and drains. The provider did not address the patient's elevated white count. He prescribed an antibiotic Amoxil for seven days, and planned to see the patient in 28-35 days. A nurse performed every other day dressing changes. As of 7/26/13, the dressing changes show that the patient is still draining copious amounts of purulent green pus from his fistula. The general surgery consultation requested 5/14/13 still has not been performed. Given the fact that the patient has had two previous hospitalizations for fevers, and presented with symptoms and lab tests suggesting systemic infection, the patient has not received timely care.

- This 41-year-old patient transferred from SAC to SVSP on 1/16/13. His medical history included hypertension, s/p aortic valve replacement in 2007 and 2009, heart failure and chronic hepatitis C infection. His eUHR problem list is blank. He is housed in ASU.[40]

  - On 3/14/13, the patient submitted a 7362 stating that he would like to see the physician about his medications. It was received and triaged on 3/15/13. On 3/18/13, the nurse documented that the patient's medication orders expired on 2/16/13 and the patient was scheduled to see the provider on 4/16/13. There is no documentation that the nurse communicated this to the patient.

  - On 3/23/13 the patient submitted another 7362 complaining that he had submitted a previous 7362 about his medications but it had not been addressed. It was received and triaged the same day. There is a brief note documenting that

[38] Intrasystem Transfer/Sick Call Patient #8

[39] On 5/21/13, his white blood cell count was elevated with increased neutrophils (WBC=11.0, normal=5.0-10.2; ANC=9980, normal=2175-7250).

[40] Intrasystem Transfer/Sick Call Patient #12.

the medications expired, but no documentation of communication with the patient.

- On 3/29/13, the patient submitted a 7362 complaining that this is his third request regarding his medications and he has not yet seen the physician. It was received and triaged on 3/29/13. There is no documentation on the form that any communication took place with the patient. In addition to not communicating with the patient, the nurses increased their workload as a result of the patient submitting multiple requests regarding his medication concerns.

- This 39-year-old arrived in CDCR in 2005 and transferred to SVSP on 4/11/11. His medical history included multiple traumas (e.g., gunshot wounds to chest, abdomen, and groin in 2001), s/p multiple surgeries with subsequent development of recurrent midline incisional hernias, femoral artery reconstruction and chronic osteomyelitis of his tibia and fibula. He also has asthma, seizure disorder, hepatitis C infection, venous stasis dermatitis, and open reduction internal fixation right leg. Review of his case shows multiple delays in care. The patient was admitted to UCSF on 2/7/13 for ventral hernia repair with mesh and was discharged on 2/21/13. A CT scan was negative for abscesses but showed right femoral head avascular necrosis. The surgeon requested follow-up in 2-3 weeks, but this did not take place. In August 2012, vascular surgery saw the patient for right lower extremity pain. At that time, the vascular surgeon did not find operative indications and requested follow-up in six months (February 2013). This also did not occur.[41]
  - On 3/26/13, the patient submitted a 7362 complaining of increasing pain and swelling in his groin area from surgery. "It is painful to walk and the left side of my abdomen is tender and continuously aches. I need to be seen urgently and I am in distress and constant pain." On 3/28/13, the nurse saw the patient, who selected a musculoskeletal assessment form. The patient was afebrile. The nurse did not describe the abdominal incision, auscultate for bowel sounds or palpate the abdomen for warm and tenderness. The nurse referred the patient routinely to a provider.

  - On 4/8/13, the patient submitted a 7362 stating that he had surgery on 2/22/13 and has not had follow-up with the surgeon, documenting: "My abdomen has a lot of scar tissue and it's hard. My groin is swollen and it's painful. On 3/8/13, I had a test on my leg for nerve damage.[42] I was supposed to see the physician within 14 days. I have not been seen and my leg is deteriorating. The pain is increasing and I need to get my leg fixed." It was received and triaged on 4/10/13. On 4/12/13, the nurse saw the patient and assessed the patient's right

[41] Intrasystem Transfer/Sick Call Patient #14
[42] An EMG showed peroneal nerve palsy.

lower leg but not the patient's groin. The nurse referred the patient routinely to the physician, who saw the patient on 4/16/13.

- On 5/8/13, Dr. S. saw the patient and documented "Vascular surgery saw. Patient states his leg is getting worse. More painful." There is no examination other than "right lower leg multiple scars, dark discoloration, pulses difficult to find." The provider completed a Request for Services (RFS) for vascular surgery.
- On 5/13/13, the surgeon who performed his hernia repair saw the patient and reported that he was doing well post-operatively but indicated he was concerned about right arterial insufficiency of his lower extremity. He recommended referral to a vascular surgeon. This report is not initialed as being reviewed. On 5/16/13, Dr. B. saw the patient for follow-up of his consultation. He made no reference to the recommendation for vascular surgery. The same day, Dr. S. wrote an urgent RFS for vascular surgery that was now two months overdue.
- On 5/23/13, vascular surgery saw the patient for right external iliac occlusion and recommended right ileofemoral bypass possible fem-fem bypass. The surgeon stated that patient has chronic pain at rest and needs treatment. The surgeon recommended that the patient have surgery on 5/25/13. On 5/31/13, Dr. S. submitted an urgent RFS for right ileofemoral bypass surgery. This was denied by the Chief P&S, who wrote "go to bypass proximal, peripheral artery." On 6/12/13, an urgent request for right ileofemoral bypass was submitted, based upon pain at rest and impending gangrene of the patient's foot. On 7/8/13, the patient submitted a 7362 requesting renewal of his lay-in. He also complained of his leg getting worse and that he was supposed to be seen weekly by a PCP. The patient was not seen but, according to the record, on or about 7/10/13, he was sent off-site and underwent bilateral ileofemoral bypass surgery. Following the surgery, he was transferred to the Corcoran GACH for postoperative care. However, as of 7/29/13, there is no documentation in the eUHR regarding his course in the hospital.

- This 56-year-old patient transferred to SVSP on 1/14/13. His medical history included latent TB and chronic hepatitis C infection, genotype 1a, seizure disorder, s/p cerebrovascular accident (CVA) with left hemiparesis, right middle cerebral artery aneurysm, and stab wound to mid-chest 1998 with extensive surgical intervention. On 1/18/13, 1/19/13, 1/24/13, and an unknown date, the patient submitted 7362s complaining that his dentures were broken and he was unable to eat. The forms were received and triaged both by nursing and dental on 1/19/13 and 1/22/13, 1/20/13 and 1/22/13, 1/26/13 and 1/28/13, and 1/29/13 and 1/30/13, respectively. On 2/1/13, the dentist reviewed all the forms and saw the patient. It does not appear that any

communication with the patient occurred from the time he submitted the first 7362 until he was seen.[43]

- A 32-year-old with a history of injection drug use, hepatitis C infection and congenital patellofemoral syndrome transferred to SVSP on 1/23/13. On 4/17/13, a nurse saw the patient urgently for complaints of chest pain and implemented the acute coronary syndrome protocol. This protocol does not prompt the nurse to measure the patient's temperature. The nurse referred the patient to the TTA and the patient was noted to be febrile (Temp=101.3°F.). Dr. B. saw the patient but did not perform a constitutional, pulmonary or cardiac review of systems (e.g., chills, fever, night sweats, weight loss, cough, hemoptysis, etc.,) or note the patient's most recent tuberculin skin test. The patient's chest x-ray showed right and left perihilar infiltrates. Dr. B.'s assessment was musculoskeletal pain and possible pneumonia. He prescribed an antibiotic and return to clinic in 1-3 days. Three days later, the patient reported coughing up blood and he was still febrile. He was sent out to the hospital and treated for pneumonia with a different antibiotic. Neither the facility nor hospital physicians considered tuberculosis in the differential diagnosis.[44]

  On 4/29/13, the patient's tuberculin skin test was positive. Without seeing the patient, Dr. M. ordered a chest x-ray, sputum smear and culture for mycobacterium, HIV test, Quantiferon, and Isoniazid[45] and Levaquin for 30 days. He did not order that a mask be placed on the patient or for him to be immediately placed in respiratory isolation as a tuberculosis suspect. No medical provider saw the patient that day. The next day, the patient was sent to the TTA wearing a mask and then sent out to the hospital as a TB suspect. A 4/30/13 chest CT showed improving multilobar pneumonia and the radiologist recommended follow-up until resolved. On 5/7/13, the patient was discharged from the hospital with sputum cultures pending, but his HIV antibody and Quantiferon tests were negative. On 5/22/13, his sputum cultures grew mycobacterium avium,[46] not mycobacterium tuberculosis. The patient has not had a follow-up chest CT as recommended by the radiologist. The primary concerns with this case are that provider did not see the patient or isolate him when active TB was suspected, and that the provider ordered TB preventive therapy when the patient had symptoms of active disease. The patient has not had the chest CT as recommended by the radiologist to determine whether pulmonary findings have resolved.

[43] Intrasystem Transfer/Sick Call Patient #16.
[44] Intrasystem Transfer/Sick Call Patient #15.
[45] Isoniazid is a medication used to treat patients in whom active tuberculosis has been ruled out, and should never be used alone for patients who are TB suspects or have confirmed TB as it may lead to INH resistant tuberculosis.
[46] Mycobacterium avium is a bacterium that can cause symptoms similar to TB. It is not spread person-to-person in the same manner as TB.

Chronic Disease Management

Methodology: We interviewed facility health care leadership and staff involved in management of chronic disease patients. In addition, we reviewed the records of 20 patients with chronic diseases, including diabetes, hypertension, HIV disease and clotting disorders, as well as other chronic illnesses. We assessed whether patients were seen in a timely manner in accordance with their disease control. At each visit, we evaluated whether provider evaluations were complete and appropriate (subjective, objective, current labs, assessment and treatment plan). We also evaluated whether the Problem List was updated and continuity of medications provided.

Findings: There were serious problems related to the management of patients with chronic diseases, both in terms of the timeliness and the quality of care, in 18 of the 20 cases we reviewed. Primary care providers do not adequately address each of the patients' chronic diseases or abnormal laboratory findings in a timely or appropriate manner. In addition, patients do not consistently see the same provider, resulting in fragmented care. While in many of these cases there were no direct adverse consequences to the patients, these problems reflect a dysfunctional chronic care system that places patients at risk of harm. Our findings are totally inconsistent with the OIG's Cycle 3 report score of 79.5% for chronic care. Our findings were also much worse than the April 2013 Dashboard's evaluation of diabetes care, which resulted in a score of 67%, and the evaluation of access and continuity of chronic care, which scored 100%. Our findings were more consistent with the April 2013 Dashboard's finding of 0% for care of patients who are receiving therapeutic anticoagulation. We also noted that several patients with coronary artery disease and diabetes that was being treated with insulin were listed in the Registry as medium, rather than high risk. In addition, in many cases, not all of a patient's chronic medical problems were noted on the problem list.

The following cases demonstrate some of the serious problems related to the timeliness and/or quality of care for patients with chronic diseases that we found.

- The patient is a 48-year-old man with diabetes, hypertension, hyperlipidemia and coronary artery disease with a history of a myocardial infarction and stent placement in 2010. He arrived at SVSP from CSP Corcoran on 11/26/12. On 7/9/12, his LDL cholesterol had been very elevated (151 mg/dL; goal less than 70 mg/dL for patients with diabetes and coronary artery disease). This had not been addressed while he was at Corcoran. A provider at SVSP saw the patient for his initial visit on 12/17/12. The provider ordered another lipid panel. It was done on 12/19/12 and revealed that the LDL cholesterol was still very elevated (124 mg/DL). On 12/28/12, the provider sent a notification form to the patient stating that his laboratory tests were essentially within normal limits. A provider saw the patient for chronic care on 1/14/13. The provider did not address the elevated LDL cholesterol. The provider did note that the patient's diabetes was not at goal. He increased the patient's medication and ordered follow-up in three months. On

1/21/13, the patient was hospitalized for acute chest pain. An LDL cholesterol level that was done in the hospital was 88 mg/dL. The cardiologist noted that he would like the LDL cholesterol to be less than 70 mg/dL and changed the patient's medication to a stronger drug at a much higher dosage. When the patient returned to SVSP on 1/25/13, the provider did not address the cardiologist's recommendation and ordered the former medication.

A provider saw the patient for chronic care on 3/19/13. He noted that the patient's hemoglobin A1C had been elevated (9%; goal less than 7%) on 2/26/13 and that he had reviewed the patient's blood sugar log that revealed that the patient's fingerstick blood sugars were elevated. The provider increased the patient's insulin and ordered follow-up in three months. On 4/5/13, the patient's LDL-cholesterol was 134 mg/dL. On 4/9/13, the provider sent the patient a notification that his laboratory tests were essentially normal. On 5/13/13, the patient's hemoglobin A1C was very elevated (11.7%). The provider notified the patient that a medical appointment was being scheduled to discuss his laboratory results. The patient transferred to Kern Valley State Prison on 5/30/13 without having been seen for follow-up at SVSP. Our review of his fingerstick blood sugars revealed that they continued to be elevated. A provider saw the patient for his intake history and physical examination at KVSP on 6/12/13. The provider noted that the patient's diabetes was poorly controlled. Despite this, his plan was to continue the patient's current regimen. He ordered laboratory tests and follow-up in four to six weeks.[47]

Assessment

The patient was not receiving appropriate care for his diabetes or hyperlipidemia. There were multiple occasions where the provider failed to appropriately address the patient's hyperlipidemia. In addition, diabetic patients whose insulin is being adjusted due to inadequate control need to be re-evaluated at least within one month.

- The patient is a 59-year-old man with a seizure disorder, hypothyroidism and a history of deep vein thrombosis. On 2/15/13, his thyroid-stimulating hormone (TSH)[48] was very elevated (126.08 mIU/L; normal range 0.4–4.5 mIU/L). A provider sent him a notification that an appointment was being scheduled to follow-up on his laboratory tests. There is no documentation that this occurred. On 3/21/13, a provider wrote an order to enroll the patent in the chronic care program for his hypothyroidism and for follow-up in 30-45 days. On 3/26/13, his TSH was lower but still elevated (28.12 mIU/L). A provider reviewed the result and noted that the patient had been receiving his current dose of

[47] Chronic care Patient #1.

[48] TSH is a blood test used to measure thyroid function. A high value indicates hypothyroidism. In a patient who is receiving thyroid replacement medication, an elevated TSH indicates that the dosage of the medication is insufficient.

Synthroid[49] for only two weeks and that it was too soon to determine if he was receiving a correct dosage. Our review of the medical record revealed, however, that the patient had been receiving the same dose since 12/27/12. The TSH was repeated again on 4/18/13, and was even more elevated (77.37 mIU/L). On 4/23/13, a provider reviewed the results and wrote "see orders." There were no orders from that date in the medical record. As of 6/28/13, the patient had not been seen for his hypothyroidism and his elevated TSH had not been addressed, despite the fact that he had seen providers on multiple occasions for other issues.

The patient has also not received appropriate care related to his warfarin therapy. On 11/18/12, a provider evaluated the patient in the TTA for his complaint of left leg swelling. The provider's assessment was leg swelling with no evidence of fracture, infection or deep vein thrombosis. His plan was for the patient to keep his leg elevated. On 11/21/12, the patient submitted an HSR stating that his leg was hurting. The nurse who evaluated him noted that he was complaining of leg pain due to swelling, that there was minimal swelling present and that the patient was limping when he was walking. She advised him to continue elevation, not to put much pressure on his leg, and to limit his intake of fluids. She scheduled him to see the physician on 11/26/12. A provider saw the patient on 11/26/12 and sent him to a local hospital to rule out a deep vein thrombosis. The patient was diagnosed with an extensive deep vein thrombosis with bilateral pulmonary edema and admitted to the hospital. He was subsequently transferred to another hospital for placement of a filter in the inferior vena cava.[50] He returned to SVSP on 11/28/12 with orders for warfarin and Lovenox.[51] The patient's INR was subtherapeutic (therapeutic range 2-3) on 11/29/12 and 12/4/12. His warfarin dosage was not increased on either occasion. Despite his subtherapeutic INRs, his Lovenox was discontinued on 12/6/12. On 12/10/12, his INR remained subtherapeutic and his warfarin was increased. On 12/11/12, a nurse saw the patient for chest pain and increased leg swelling. The nurse noted that she referred the case to the provider and that there were no further orders. There was no documentation that the provider evaluated the patient. On 12/17/12, the patient's INR was still subtherapeutic but his warfarin was not increased. On 12/20/12, the patient was seen in the TTA for increased pain in his leg. He was sent to the local hospital emergency room. Studies revealed that there was probable extension of the clot and that his INR was 1.52. The emergency room physician noted that the patient was "somewhat anticoagulated although not therapeutic as ideally." He recommended increasing the dosage of the warfarin to 10 mg. The patient returned to SVSP later that day and the provider increased the dosage

[49] A medication for treating hypothyroidism.

[50] The purpose of the filter is to prevent emboli (pieces of a blood clot that break off) from being carried by the blood to the lungs.

[51] Lovenox is an anti-coagulant that is given intramuscularly. It is often given to patients when warfarin therapy is initiated to cover the patient until the INR becomes therapeutic.

of warfarin to 8 mg and wrote an order to recheck the INR in four days and have the primary care provider adjust the warfarin dosage. A provider saw the patient on 12/24/12 and wrote an order to increase the warfarin to 10 mg for three days and then to give 5 mg per day after that. (There is no documentation as to why the dosage was to be lowered.) On 12/28/12, a provider noted that the patient's INR was 1.5 and increased the dosage of warfarin from 5 to 8 mg. On 12/30/12, a provider noted that the patient's INR was subtherapeutic (1.8) but despite this, decreased the dosage of warfarin to 7.5 mg. On 1/3/13, a provider noted that the INR was 1.5 and increased the dosage of warfarin to 10 mg. On 1/23/13, the INR was supratherapeutic (3.7) and the provider wrote an order to hold the warfarin for two days and then restart it at a dosage of 8 mg. On 1/26/13, the patient was seen in the TTA complaining of leg pain. His INR was 1.9 at that time and the provider increased his dosage of warfarin to 10 mg. Subsequently, the patient's INR was therapeutic on 2/6/13, subtherapeutic on 2/11/13 and 2/12/13, and then therapeutic on 2/15/13. On 2/16/13, the patient was sent to a local emergency room for bilateral pain and swelling of his testicles. He was subsequently transferred to a regional medical center for further care. He returned to SVSP on 2/18/13. There were no medical records from the regional medical center in the eUHR. On 2/19/13, a provider saw the patient and noted that his INR was nontherapeutic and increased his warfarin to 12 mg. On 2/25/13, the patient refused to have his blood drawn for an INR. The provider decreased his warfarin dosage to 10 mg. The following day, 2/26/13, the patient's INR was supratherapeutic (3.9). On 3/1/13, a provider wrote an order for the INR to be repeated on a stat (immediate) basis on 3/4/13. The INR was not repeated until 3/7/13 at which time it was supratherapeutic (8.5). The provider wrote an order to stop the warfarin and to restart it on 3/12/13 at a dosage of 8 mg. The patient's INR was 7.5 on 3/11/13 and 4.3 on 3/12/13. The provider wrote an order to recheck the INR in the morning. It was not rechecked until 3/14/13, at which time the INR was 1.5. A repeat INR on 3/15/13 was 1.3. The patient's warfarin was restarted on 3/15/13. Since that time, his INR has been monitored and his warfarin has been adjusted appropriately.[52] .

Assessment

There were problems related to the care and treatment of both the patient's hypothyroidism and his anticoagulation. Of special concern is the fact that the Lovenox was discontinued before his INR had become therapeutic. The failure to appropriately manage his anticoagulation is particularly concerning given the massiveness of his blood clot and his pulmonary emboli. In addition, there was a problem related to nursing care. The nurse who saw the patient on 11/21/12 should have referred him to a provider on an urgent basis for further evaluation.

[52] Chronic Care Patient #2.

- The patient is a 69-year-old man with diabetes, hypertension, renal insufficiency, hyperlipidemia, anemia and asthma. His hemoglobin A1C had been 7.7% on 5/17/12. On 5/21/12, a provider saw him and noted that, due to his renal failure, his hemoglobin A1C goal would be 8%.[53] The patient was subsequently seen for chronic care on 8/7/12, 11/15/12, and 2/11/13, but his hemoglobin A1C was not repeated until 5/17/13. At that time it was very elevated (10.6%), signifying that his diabetes was poorly controlled. A provider saw the patient on 5/29/13 and noted that the results were not in the eUHR. A provider saw the patient on 6/18/13 for chronic care of his asthma. The provider did not address the patient's diabetes at that time. In addition, the patient's blood pressure was elevated (143/86 mmHg) on 5/29/13 and the provider did not address this. Furthermore, the patient's LDL cholesterol had been elevated (112 mg/dL) on 11/28/12. This had not been addressed as of 6/28/13.[54]

  Assessment

  The patient did not receive appropriate care for his diabetes or his hyperlipidemia. Patients with diabetes need to have their hemoglobin A1C checked at least every six months. Since the patient's hemoglobin A1C had not been checked in one year, it is not possible to determine how long his diabetes had been poorly controlled. In addition, the blood pressure goal for patients with diabetes is 140/80 mmHg. Furthermore, his elevated LDL cholesterol had not been addressed for almost seven months.

- The patient is a 69-year-old man with diabetes, hypertension, hyperlipidemia, emphysema and serious cognitive deficits. He arrived at SVSP on 2/11/13 from the Substance Abuse Treatment Facility (SATF). On 2/21/13, his hemoglobin A1C had been 9.4% and his LDL-cholesterol had been 138. He refused his initial chronic care visit on 2/15/13. A provider saw him on 3/4/13 and noted that his diabetes and hypertension were not at goal. He adjusted his medications and ordered follow-up in 30 to 45 days. He noted that the patient had a questionable history of hyperlipidemia for which he was taking medication, but did not address his elevated LDL cholesterol from 2/21/13. He did not address the patient's emphysema. A provider saw the patient next for chronic care on 4/10/13. The provider noted that his fingerstick blood sugars were not well-controlled and noted that control was difficult due to the patient's "disability." His plan was to monitor and follow-up in 30 days. He did not address the patient's elevated LDL cholesterol or his emphysema. The patient had not been seen for follow-up and had not had his hemoglobin A1C repeated[55] as of 6/28/13.[56]

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[53] The American Diabetes Association recommends a goal of less than 7% for most patients with diabetes. However, a goal of less than 8% is recommended for patients with co-morbid conditions.

[54] Chronic Care Patient #3.

[55] Diabetic patients who are not well-controlled need to have their hemoglobin A1C checked every three months.

[56] Chronic Care Patient #4.

Assessment

The patient was not receiving appropriate care for his chronic illnesses.

- The patient is a 41-year-old man with asthma, a seizure disorder, and a history of deep vein thrombosis with protein C deficiency (a clotting disorder). He arrived at SVSP from CSP Sacramento on 10/3/12. His medications were continued, including warfarin 5 mg per day. A provider saw him for his intake examination on 10/11/12. The provider noted that the patient had a history of asthma since childhood and a seizure disorder. He did not document any further history related to the patient's asthma or seizure disorder. He ordered follow-up in two to three weeks. The provider saw the patient on 10/29/12 for his chronic care. The provider noted that the patient had a history of intubation (no further details were supplied) and was using albuterol and steroid inhalers. (Review of his records revealed that the patient had been using a steroid inhaler at another facility two years before and was not currently using one.) The provider further noted that the patient stated that he had exacerbations of his asthma every three to four months (the provider did not note when the last one was), that he awakened three times per week because of his asthma, that he used his albuterol inhaler every six hours,[57] and that his asthma interfered with his walking to meals. The provider's plan was to continue the albuterol and steroid inhalers. (As noted above, the patient was not receiving a steroid inhaler and the provider did not order one.) The provider did not address the patient's seizure disorder. He ordered follow-up for asthma in five to six months and for the patient's seizures in one month. The provider saw the patient for his seizure disorder on 11/29/12. He noted that the patient had a history of seizures since childhood as a result of trauma. He did not note when the patient's last seizure had been. He also noted that the patient's most recent Dilantin blood level had been subtherapeutic on 10/23/12 but did not check for medication compliance or further address this issue with the patient. The provider noted that the next visit would be "as scheduled." On 4/22/13, the patient was seen by the provider for follow-up of a TTA visit. The provider did not address the patient's asthma or seizure disorder at that time. However, he wrote an order that day to reschedule the patient's chronic care visit for asthma in ninety days and his chronic care visit for seizures in sixty days. In addition, the patient's INR was subtherapeutic on 5/20/13. The provider increased the dose of warfarin on 5/22/13 and ordered a repeat INR for 5/28/13. On 5/29/13, the provider saw the patient and noted that the patient stated that the INR had been drawn that morning. The provider wrote an order to continue the current dose of warfarin and for the patient to return on 6/5/13. The patient was not seen that day and his INR was not repeated until 6/17/13. At that time, it was elevated (4.2). On 6/18/13, a provider increased the dosage of warfarin and ordered a repeat INR in three days. A provider saw the patient on 6/20/13 and noted

[57] Use of an albuterol inhaler more than two days a week for symptom relief generally indicates inadequate control and the need to increase the treatment.

that the INR had been 2.6 on 5/29/13. He did not note the elevated INR from 6/18/13. The INR was not repeated until 6/27/13, at which time it was therapeutic.

In addition, the patient was seen in the TTA on 6/14/13 for a complaint of dizziness. His Dilantin level was found to be elevated (31.9 mg/L; normal 10-20 mg/L with a toxic level of > 35). The patient stated that until two days before, he had not been taking his Dilantin for a while because he had not been having any seizures. At that time, he had a seizure and took an excessive amount of Dilantin. The provider stopped the Dilantin and rechecked a blood level on 6/26/13. At that time, it was not detectable in the blood. The provider restarted the Dilantin.[58]

Assessment

The patient is not receiving adequate care for his chronic problems. In terms of his seizure disorder, a provider did not discuss compliance with the patient despite the fact that his Dilantin level had been subtherapeutic since 10/23/12. Furthermore, the patient's Dilantin level should have been rechecked within a few days so that his Dilantin could have been restarted sooner.

- The patient is a 53-year-old-man with diabetes, hypertension and hyperlipidemia. Review of his medical record reveals that his blood sugars have been poorly controlled since May 2012. At that time, his hemoglobin A1C was 10.9%. While at times the patient has not been fully compliant with his treatment, for the most part he has been compliant. Despite the inadequate control of his diabetes, the dosage of his Lantus insulin has not been adjusted since May 2012. On 12/18/12, a provider saw him for chronic care and noted that his diabetes and hypertension were not at goal. The provider's plan was to continue the current medications, to order blood pressure checks every week for 90 days, and to see the patient again in 90 days. The blood pressure checks were performed as ordered and most of the readings were elevated. On 1/13/13, the provider added a sliding scale of regular insulin to the patient's regimen. The provider next saw the patient for chronic care on 3/11/13. The patient's blood pressure remained elevated at that time (132/87 mmHg, goal=<140/80 mmHg). The provider reviewed the patient's recent fingerstick blood sugars (most of which were in the 200s with a couple of readings over 300). The provider noted that the patient was complaining of increased urination, blurred vision, sweating, shortness of breath, dizziness and hypoglycemic episodes. He did not document any further history related to any of these complaints. His plan was to continue the current medications, to discontinue the blood pressure checks, and to have the patient follow-up in five to six months. On 5/23/13, the patient's hemoglobin A1C was elevated (9.6%).[59]

[58] Chronic Care Patient #6.
[59] Chronic Care Patient #7.

Assessment

The patient was not receiving adequate care for his diabetes or hypertension. On 3/11/13, the provider did not address the patient's symptoms or his elevated blood sugars. In addition, since the patient's diabetes was not controlled, he needed to be seen for follow-up much sooner than five to six months. Furthermore, sliding scale insulin is not an appropriate manner in which to address long-term blood sugar control. The patient's Lantus insulin needs to be adjusted and/or fixed doses of regular insulin need to be added to his regimen. The provider also did not address the patient's elevated blood pressure.

- The patient is a 53-year-old man with diabetes, hyperlipidemia, coronary artery disease with a history of four heart attacks, congestive heart failure, hypertension, sleep apnea, chronic obstructive pulmonary disease (COPD) requiring oxygen, and a history of a stroke. A provider saw him for chronic care on 3/8/13. His blood pressure was elevated (159/95 mmHg) at that time. The provider increased the patient's blood pressure medications and ordered blood pressure checks two times per week for 90 days. The blood pressure checks were performed as ordered and his blood pressures remained elevated, with readings as high as 176/97 mmHg. The provider next saw the patient on 4/5/13 for another problem. The patient's blood pressure was 177/108 mmHg at that time. The provider noted that the patient was compliant with his blood pressure medications and that his blood pressure was not at goal. His plan was to continue the current medications. A provider saw the patient on 5/10/13 for another problem. The patient's blood pressure was 146/102 mmHg at that time. The provider did not address the patient's blood pressure. The patient was next seen on 5/23/13. His blood pressure was 180/95 mmHg and the provider increased his blood pressure medication. In addition, the patient's LDL-cholesterol was elevated (118 mg/dL) on 5/22/13. The provider saw the patient on 6/5/13 and did not address the elevated LDL cholesterol.[60]

  Assessment

  The patient did not receive appropriate care for his hypertension or hyperlipidemia.

- The patient is a 47-year-old man with asthma, hyperlipidemia, coronary artery disease, and Parkinson's disease. He arrived at SVSP from High Desert State Prison (HDSP) on 10/25/12. His medications included an albuterol inhaler and Dulera[61] for his asthma and nitroglycerin for angina. On 7/13/12, at HDSP, his LDL cholesterol had been extremely elevated (237 mg/dL). Other than changing the patient's simvastatin from self-administered to nurse administered this was not addressed at his prior facility. On 10/31/12, the provider saw the patient for his new arrival examination. The provider noted that the patient had a history of hyperlipidemia, Parkinson's disease and coronary

[60] Chronic Care Patient #8.

[61] Dulera is a combination inhaler of a long-acting beta agonist and a steroid used as maintenance therapy in asthma.

artery disease with a heart attack in 2004. The provider did not document a history related to the patient's Parkinson's disease or coronary artery disease. The provider did note that the patient had a history of asthma since childhood and that he was awakening at night (the provider did not note whether this was due to the patient's asthma). The provider did not document the history related to the frequency of inhaler use or recent exacerbations. His assessment was COPD with an asthmatic component. (There was no prior history of COPD.) The provider ordered ipratropium (a medication used in the treatment of COPD). The provider also changed the patient's cholesterol medication from simvastatin 40 mg to Lipitor 20 mg. (Lipitor is two times as effective as simvastatin in lowering cholesterol. Therefore, simvastatin 40 mg and Lipitor 20 mg are essentially equivalent.) According to the Pharmacist-in-Charge, Lipitor is non-formulary and the pharmacy has a standing order to change it to an equivalent dose of simvastatin. In this case, however, instead of changing the Lipitor to 40 mg of simvastatin, the pharmacy changed it to 80 mg of simvastatin by mistake (this error continued for six months until 4/3/13, when a provider reduced the dosage). The provider saw the patient for follow-up on 11/26/12. He did not document a history related to recent asthma exacerbations, frequency of inhaler use or nighttime awakening. He did note that the patient complained of "poor sleep" but did not state whether this was related to the patient's asthma. He did not adjust the patient's therapy and ordered follow-up in five to six months. The provider also noted that the patient was also complaining of pain from spasms. He did not document any further history related to this problem and did not examine the patient. His plan was to order Elavil (an antidepressant commonly used to treat pain) and Baclofen (a muscle relaxant). He did not document the history related to the patient's coronary artery disease. On 12/19/12, the patient was seen for an exacerbation of his asthma. The provider noted that the patient stated that he had been having difficulty breathing for the last two weeks, that he had been awakening most nights and that he had needed his albuterol inhaler more than two times per day for the last two weeks. The provider treated the acute exacerbation and increased the patient's use of Dulera to three times per day. (The maximum recommended use of Dulera is two times per day.) The provider saw the patient for follow-up on 1/9/13 and noted that his asthma was improved. He reduced the frequency of the Dulera.

The patient's LDL was not repeated until 3/22/13. It was still extremely elevated (LDL-C=231). The patient was seen via telemedicine on 4/3/13. His blood pressure at that time was elevated (BP=163/95 mmHg). The telemedicine provider noted that the patient had stopped taking his medications one week before because he didn't feel well and felt like he was taking too much medication. The provider added that it was difficult to discern how often the patient was using which of his inhalers. His assessment was that the patient's lipid studies were dramatically "elevated" and that he advised the patient to re-start his simvastatin. He did not address the patient's elevated blood

pressure. On 4/20/13, the on-site provider discontinued the simvastatin 40 mg and ordered Lipitor 20 mg. (As noted above, 40 mg of simvastatin and 20 mg of Lipitor are equivalent in terms of efficacy.)[62]

Assessment

There are numerous problems with the care provided to this patient. His extremely elevated LDL cholesterol has not been appropriately managed. Furthermore, the pharmacy dispensed an incorrect dosage of the patient's cholesterol lowering medication. In addition, the provider began treating the patient for COPD rather than adjusting his asthma medications when there was no evidence that the patient was suffering from COPD. The provider also ordered a higher than recommended dosage of Dulera. Moreover, the provider did not adequately assess the patient's complaint of spasms and the telemedicine provider did not address the patient's elevated blood pressure.

- The patient is a 52-year-old man who arrived at SVSP from Wasco State Prison on 11/13/12. On 12/8/12, he was sent to a local hospital for a complaint of painful leg swelling and was diagnosed with a deep vein thrombosis. He returned to SVSP on 12/10/12 with orders for warfarin. On 12/14/12, the patient's INR was subtherapeutic (1.0). The provider noted that the patient had not received his medication on 12/12/12 or 12/13/12.

  On 1/9/13, the patient's INR was 1.8. On 1/11/13, the provider increased the dosage of his warfarin. On 1/17/13, the patient's INR was therapeutic (2.3). The INR was not checked again until 2/10/13, at which time it was 4.2. Despite noting that the therapeutic range for the patient's INR was 2-3, his assessment was that the INR was therapeutic. He did not adjust his medication and ordered a repeat INR for the next day. The patient was seen in the TTA that evening for a complaint of dizziness. The nurse's note states that the patient was seen by the physician but there is no documentation of that. The patient was seen again in the TTA the following morning, 2/11/13, for the same complaint of dizziness. He was sent to a local hospital for further evaluation and diagnosed with anemia secondary to gastrointestinal bleeding and a clotting problem due to warfarin. His hemoglobin was 6.4 (normal range 13.5-7.0) and his INR was so high at that time that it could not be measured. The patient recovered and returned to SVSP on 2/26/13.[63]

  Assessment

  The patient did not receive appropriate care related to his warfarin therapy. The patient's INR had been subtherapeutic on 1/11/13. The provider increased the dosage

[62] Chronic Care Patient #10.
[63] Chronic Care Patient #11.

of the patient's warfarin and re-checked the INR on 1/17/13, at which time it was therapeutic. The INR was not checked again for 3½ weeks, at which time it was supratherapeutic. The INR needs to be monitored on at least a weekly basis until it has been stable for at least two or three times. Once determined to be stable, it can be checked less frequently (at least monthly). The failure to appropriately monitor the patient's anticoagulation therapy resulted in a potentially life-threatening gastrointestinal bleed and a two-week hospitalization. We found a similar problem in a number of cases of other patients who were receiving warfarin. Luckily, in those cases it did not result in harm to the patient. Also, the provider who saw the patient on 1/10/13 and noted that his INR was 4.2 should have held the warfarin per the CCHCS guidelines. Moreover, there is no documentation of the care the patient received in the TTA the night prior to his admission. In addition, the patient did not receive two doses of his warfarin shortly after his initial hospitalization on 12/12/12.

- The patient is a 55-year-old man with diabetes, hypertension and hyperlipidemia. The patient's LDL cholesterol had been therapeutic on 2/27/12 (51 mg/dL) and 10/26/12 (54 mg/dL). The provider discontinued the patient's cholesterol lowering medication on 5/28/13, stating that it had been "beyond goal" for more than six months. The provider did not order any follow-up testing.[64]

  Assessment

  It is acceptable practice to discontinue the medications to determine if the patient still requires medication. However, if a provider decides to do this, he/she needs to re-check a lipid panel within a few months to ensure that the LDL cholesterol has not increased above an acceptable level.

- The patient is a 54-year-old man with asthma/COPD, congestive heart failure, hyperlipidemia, a seizure disorder and a prosthetic mitral valve (mechanical). Because of his mechanical mitral valve, he is receiving warfarin with a therapeutic range of 2.5 to 3.5. On 3/6/13, his order for warfarin 5.5 mg expired. The warfarin was not reordered until 3/8/13, at which time it was ordered at a dose of 3 mg. (There is no documentation as to why the provider ordered this lower dose.) On 3/13/13, the patient's INR was sub therapeutic (1.3). His warfarin was increased to 5.5 mg on 3/14/13. A repeat INR on 3/18/13 was still subtherapeutic (1.7). On 3/19/13, a provider increased the warfarin to 6 mg. On 3/20/13, another provider increased it to 7 mg. On 3/25/13, the patient's INR was supratherapeutic (8.7). The provider held his warfarin until it had decreased and then restarted the warfarin.

[64] Chronic Care Patient #12.

A provider saw the patient for chronic care on 3/25/13. The provider administered the *Asthma Control Assessment Tool*,[65] which indicated that the patient's asthma was in poor control (including that he was using his inhaler on a daily basis and that he was awakening about one-half the nights). In addition, the patient answered yes to the question: *In the last month, has your asthma caused so much breathing difficulty that you became frightened?* This question is accompanied by the instruction that if the patient answers "yes," the provider needs to further explore it. The provider did not further address the patient's asthma during this visit and did not adjust his medication. The patient has been seen multiple times since then in anticoagulation clinic but has not had a chronic care visit related to his asthma. On 5/24/13, the provider in the anticoagulation clinic noted that the patient's breathing was controlled with his inhaler. The provider did not note the frequency of inhaler use, recent exacerbations, or if the patient was awakening at night from his asthma. [66]

Assessment

The patient did not receive appropriate care related to his anticoagulation therapy or his asthma.

- The patient is a 46-year-old man with diabetes, hyperlipidemia, hypertension, pacemaker, a prosthetic aortic valve (mechanical) and a history of two strokes (1993 and 1997). The therapeutic range for his INR is 2-3. On 2/26/13, his INR was supratherapeutic (3.7). On 2/28/13, the provider decreased his warfarin from 5.5 mg to 5 mg. On 3/4/13, another provider decreased it to 4.5 mg. (There was no documentation as to why the provider did this.) On 3/5/13, the INR was therapeutic. On 3/18/13, the INR was subtherapeutic (1.9). On 3/19/13, the provider increased the warfarin to 5 mg. On 3/27/13, the provider noted that the INR had been 2.3 on 3/25/13 and mistakenly stated that it was subtherapeutic. (As noted above, an INR of 2-3 is therapeutic for this patient.) The provider increased the warfarin to 6 mg four days per week and 5 mg three days per week). On 4/2/13, the patient's INR was 2.1. On 4/4/13, a provider decreased the warfarin to 4 mg without any explanation as to why he was doing this. On 4/8/13, the patient's INR was 1.7. On 4/10/13, a different provider saw the patient and noted that his INR was subtherapeutic and that it had been therapeutic on his prior dose of warfarin. He added, "However, warfarin dose was decreased by another provider on 4/4/13??." The provider increased the warfarin to the prior dose and ordered Lovenox to be given until the INR was therapeutic. On 4/15/13, the INR was still subtherapeutic (1.2). On 4/17/13, a provider increased the warfarin dosage to 6 mg. On 4/22/13, the INR remained at a subtherapeutic (1.7) level. On 4/25/13, a provider increased the warfarin dosage to 10 mg for two days, followed by 7 mg four days per

[65] A standardized series of questions developed by the American Lung Association to assess the degree of control of a patient's asthma.
[66] Chronic Care Patient #13.

week and 6 mg for three days per week. The provider also discontinued the Lovenox. On 4/29/13, the patient's INR was therapeutic (2.4). The provider increased the warfarin dosage to 7 mg without an explanation as to why he was doing this. On 5/6/13, the INR was supratherapeutic (3.6). The provider decreased the warfarin dosage to 7 mg five days per week and 6 mg two days per week. On 5/13/13, the patient's INR was therapeutic (2.7). The provider ordered a repeat INR for 6/17/13. On 6/5/13, another INR was done and was supratherapeutic (4.97). The result was reported to the facility the same day. On 6/7/13, the provider reduced the patient's warfarin dosage to 6 mg. In addition, on 9/24/12, the patient's triglycerides were elevated (295 mg/dL; (normal < 150 mg/dL). This had not been addressed.[67]

Assessment

The patient's care related to his anticoagulation therapy was inconsistent and fragmented. Two issues in this case are of particular concern. One is that the provider who saw the patient on 5/13/13 needed to order a repeat INR within one week, since the patient's INR had only been in the therapeutic range one time. The other concern is that the patient's supratherapeutic INR on 6/5/13 needed to be addressed the same day the results were sent to the facility or at least by the following day. In this case, the result was not addressed until two days later. In addition, his high triglycerides had not been addressed.

- The patient is a 52-year-old man with hypertension, hyperlipidemia, asthma and coronary artery disease with a history of stent placement. On 2/20/13, a provider saw the patient for follow-up of a TTA visit on 2/14/13 for chest pain. The physician noted that the patient stated that he had been having difficulty breathing over the last two weeks and that he had been using his inhaler on a daily basis. The clinician did not address the patient's asthma in his assessment or plan. On 5/24/13, the provider noted that the patient was complaining of shortness of breath and that he had a history of asthma. The provider did not obtain a history related to the patient's asthma (i.e., frequency of inhaler use, recent exacerbations or nighttime symptoms). In addition, on 5/31/13, blood tests were performed which revealed that his random blood sugar was elevated (179 mg/dL; normal range 70-110 mg/dL). The provider sent him a notification form stating that his laboratory tests were essentially normal and that no physician follow-up was required.[68]

  Assessment

  The patient did not receive appropriate care related to his asthma. Furthermore, the provider did not follow-up on the patient's elevated blood glucose. The provider needed

[67] Chronic Care Patient #14.
[68] Chronic Care Patient #17.

to order a fasting blood sugar or hemoglobin A1C to determine whether the patient had either diabetes or pre-diabetes.

- The patient is a 72-year-old man with diabetes, hypertension, congestive heart failure, hyperlipidemia, peripheral vascular disease and a recent stroke. He had been hospitalized from 3/22/13 to 4/2/13 for altered mental status, a urinary tract infection, and a stroke. Following his hospitalization, he was transferred to the GACH at CMC. On 4/5/13, he returned to SVSP. The intake nurse noted that she discussed the patient with the on-site emergency room physician but that the physician did not see the patient. The patient was referred to see the primary care provider in 3-5 days. The provider saw the patient on 4/8/13. The provider did not perform an appropriate physical examination (i.e., he did not examine the patient's chest, heart or abdomen). On 4/16/13, the patient's alpha-fetoprotein (a blood test used to screen for some cancers) was elevated (13.6ng/ml; normal < 6.1 ng/ml). We were unable to determine who ordered the test or why it was ordered. As of 6/28/13, the abnormal result had not been addressed.[69]

  Assessment

  The patient did not receive appropriate care when he returned to SVSP on 4/8/13. Given his extensive medical history and recent hospitalization, the physician needed to perform a thorough physical examination. In addition, a provider had not followed up on the patient's abnormal alpha-fetoprotein.

- The patient is a 51-year-old man with asthma, diabetes, and hypertension. The provider saw him for chronic care on 4/11/13. The patient had been ordered an albuterol inhaler and Flovent (an inhaled corticosteroid) for his asthma. The provider noted that the patient's asthma was not well controlled and added Dulera (an inhaled medicine that is a combination of two medications, one of which is a corticosteroid) to his current regimen. The provider next saw the patient for chronic care on 5/30/13. The provider did not address the patient's asthma at that time.[70]

  Assessment

  The patient did not receive appropriate care for his asthma. It is not appropriate to order two different steroid inhalers at the same time. When the provider added the Dulera, he needed to discontinue the Flovent. In addition, despite changing the patient's asthma regimen on 4/11/13, the provider did not address the patient's asthma at the chronic care visit on 5/30/13.

- The patient is a 43-year-old man with diabetes, hyperlipidemia, hypertension and the mechanical aortic valve. The therapeutic range for his INR is 2.0-3.0. On 2/19/13, his INR

[69] Chronic Care Patient #18.
[70] Chronic Care Patient #19.

was elevated (4.2). The results were reported to the facility early in the morning of 2/20/13. The provider did not review and sign the results until 2/22/13. The provider did not address the elevated result at that time. It was not addressed until 3/15/13, when a provider ordered a repeat test. The patient refused the blood test on a couple of occasions and it was not done until 3/27/13. The repeat test revealed that the INR was within the therapeutic range (2.8).[71]

Assessment

The patient did not receive adequate management of his anticoagulation therapy. The elevated INR needed to be reviewed by the physician the day it arrived at the facility or at least by the following day. Furthermore, it was not addressed by a provider until almost a month after it had been ordered. While this delay did not result in any untoward consequences, it could have resulted in serious harm to the patient.

Pain management and use of controlled substances

On the day of our visit, the pharmacy had on record 126 prescriptions for morphine and 157 prescriptions for methadone. We did not determine how many of these patients were on both morphine and methadone. So the number of individual patients receiving either one or both of these two narcotics medications ranges from approximately four to eight percent of the population of SVSP. This is a high number. One physician alone accounted for 51 of the 283 prescriptions for these two medications or 18% of the prescriptions, even though he is under monitoring for his prescribing practices.

When patients are in pain, they deserve medication sufficient to address their condition. We describe in another section of this report a patient[72] with sickle cell disease who had very poor management of his pain, including not having a documented pain plan, not having adequately documented pain history, and occasional reduction of his pain prescription medication without a physician evaluation. He experienced multiple hospitalizations from painful sickle cell crises because of a lack of pain management at the facility and failure to provide adequate pain control to the patient.

Despite this, there are numerous prescriptions for narcotic pain medications without adequate evaluation or indication. The Medical Board of California has Guidelines for Prescribing Controlled Substances for Pain,[73] which established standards for prescribing narcotic medications. These standards have expectations that when prescribing narcotic medication, physicians must accomplish a history and physical examination, develop a treatment plan stating objectives by which the treatment can be evaluated, discuss risks and benefits with the patient, periodically review the course of pain treatment, assess the appropriateness of

[71] Chronic Care Patient #20.
[72] Hospital Patient #4.
[73] The Medical Board of California *Guidelines for Prescribing Controlled Substances for Pain* which are found at the following URL: http://www.mbc.ca.gov/pain_guidelines.html.

continuation of medication and refer for additional consultation for complex pain. The basis for using or withholding narcotics should be documented. And finally, the history is to include an assessment of the pain, substance abuse history, prior history of treatment, underlying coexisting conditions and documentation of the presence of a recognized medical indication for use of a controlled substance. We found that SVSP providers did not adhere to the Medical Board of California guidelines with respect to prescription of controlled substances.

One example was a patient[74] who had a history of asthma, hypertension, prior deep vein thrombosis and a prior history of gunshot wound resulting in partial paralysis. He also used a straight catheter for intermittent self-catheterization because of complications of his gunshot wound. At one visit on 12/18/12, the patient was seen primarily for obtaining catheter supplies but incidentally complained of low back pain. The physician documented almost no history except that the patient had low back pain. The physician noted that the patient was in mild to moderate distress from the low back pain; no neurological examination was done. This physician's writing was extremely difficult to read but it appeared that the only physical examination related to pain was that the patient had no spasm or trauma and had tenderness to palpation. On the basis of this history and physical examination, the physician assessed that the patient had chronic low back pain and, based on the patient's statement that nothing works except morphine, the physician prescribed 30 mg of morphine for 90 days. This is inappropriate and is not consistent with the Medical Board of California Guidelines.

Another patient[75] who is also discussed in the mortality review section, had cirrhosis, portal hypertension and end stage liver disease. Our span of review was 10 months, but during that time, the patient was on continuous dose of 90 mg of morphine a day without a documented clinical indication and without having a history or physical examination establishing a medical indication for narcotic medication. This person had a history of substance abuse.

Another patient[76] had HIV infection, high blood lipids, cirrhosis, chronic hip pain and chronic ankle pain from an old injury. He had been on a very large dose of morphine for six months (240 mg a day in four divided doses). None of the physician evaluations at SVSP included a thorough history, physical examination, pain assessment or documented established indication for this amount of narcotic. During this period, physician examinations were deficient. As examples, on 8/29/11, a physician documented sore feet and limping but there was no other history or physical examination. On 10/24/11, a physician note documented no history of pain and no physical examination due to pain. On 1/9/12, the physician documented no history or physical examination for pain but a 60-day appointment for pain management was scheduled. On 2/23/12, the patient was admitted to the hospital for cellulitis of the ankle and left leg and surgical debridement was performed. The patient was discharged to the prison with a wound

[74] Hospital Patient #6.
[75] Mortality Review Patient #3.
[76] Chronic Pain Patient #1.

VAC and on antibiotics. The wound VAC was prematurely removed at the prison. On 3/16/12, the physician noted only that the patient had pain in the ankle. There was no other assessment of the pain or physical examination detailing the pain. The physician did document that the patient had been identified as diverting narcotics. Nevertheless, the physician continued the prescription of 240 mg of morphine a day. On 3/23/12, the pain history was poor and limited to the following quote, "complaining of pain to left ankle on MS IR 60 mg QID." There was no examination detailing pain or establishment of an indication for the drug. The patient was subsequently admitted to a hospital for osteomyelitis and discharged to the CMC GACH. The physician at CMC wrote the following note:

> "Finally, the patient's requirement for narcotic analgesics appeared to be out of proportion to the objective findings. It is noted that the patient had been on high doses of morphine for a long period of time. No doubt, he had developed tolerance if not dependence to these agents and this likely will be a point of contention going forward as the patient continues to complain of severe ankle pain."

The patient returned to SVSP in June of 2012. Upon return, the patient continued to have limited history and physical examinations for pain. There was one "pain management" clinic note performed by the primary care physician in February of 2013. This note did use a pain scale but the physical examination consisted of stating that the patient had limited range of motion, that the patient was on a wheelchair and had difficulty standing and had a tender lumbosacral spine and ankle. His final visit was 6/4/13, when there was no examination of the hips or ankles and no discussion of pain. The physician note does not include a pain assessment nor does it include pain as a problem; yet the physician continued to prescribe a high dose of morphine.

This patient was maintained on very high doses of morphine for a two-year period for a condition that would normally be treated with non-steroidal pain medication. His pain management included almost no history, physical examinations, assessments or establishment of an indication for morphine. There was no pain medication therapeutic plan. At least one CDCR physician recognized that the patient did not have pain-warranting use of narcotics and noted that this had probably resulted in dependence. This unprofessional practice results in harming the patient by promoting addiction.

Another patient[77] was on chronic high dose morphine (180 mg a day) for over two years for chronic low back pain. This patient had a CT scan of his back showing diffuse disc bulging with mild to moderate stenosis. He also had evidence on an EMG of moderate to severe peroneal nerve compression. These abnormalities were not of the severity requiring surgical intervention and often can be treated with non-steroidal medication. The initial physician note starting narcotic medication for his condition pre-dated the eUHR and could not be reviewed. However,

[77] Chronic Pain Patient #2.

notes at SVSP consistently did not include adequate history or physical examination establishing an indication for narcotics or continuing need for narcotics.

The first available eUHR note for this patient was 11/4/11, which included no history of back pain and documented no musculoskeletal findings. The next evaluation was 11/8/11. The physician documented the abnormal EEG findings of nerve compression but justification for use of morphine was not documented. The physician also did not describe functional capacity, history of pain or a discussion of use of other modalities in treatment of pain. Morphine was prescribed.

On 1/17/12, a chronic pain evaluation took place. The physician documented low back pain radiation to the thigh with pain scaled as 3 of 10 in severity currently and 8 of 10 over the past week. The physician noted that the pain affected his activity, mood, ability to exercise and work. A physical examination was done and was consistent with his disc disease. The patient was maintained on high doses of morphine. There was no discussion of potential for addiction, no attempt at exercise, physical therapy, psychological therapy or exercise. Morphine was the sole element of his treatment plan.

On 3/7/12, the patient saw a telemedicine physical medicine consultant regarding his back pain. The consultant concluded that the patient had left radicular low back pain with mild/moderate stenosis with tight hamstrings and iliopsoas and core deconditioning. He recommended weight loss, a cone device as treatment of the low back pain, and physical therapy. He did not recommend additional epidural injections as the patient already had three injections. A 2-3 month follow-up was recommended but the narcotic pain medication was not addressed and medication use was not reviewed. The primary care physician did initiate a physical therapy request but there was no evidence that this ever occurred.

The patient then went into administrative segregation. A 4/3/12 physician appointment did not occur, but the reason was not specified. The patient placed a 7362 health request to see a physician because his appointment was cancelled on three subsequent occasions. A nurse documented that the patient would be scheduled for 6/5/12, but this appointment did not occur either. The physician finally saw the patient on 6/7/12. The physician noted that the patient had seen a specialist on 3/17/12 but that the consultation report was not available yet. This was at minimum a 3-month delay in obtaining a report. The physician took no history. The physical examination consisted of noting a limp, documenting decreased range of motion and documenting a normal neurological examination. The recommendations for alternate modalities were not noted, ostensibly because the physician did not have a report. Morphine was renewed and no other modalities were attempted. The reason why physical therapy had not started was not noted.

On 6/13/12, the consultant's report was reviewed and physical therapy was reordered. The physician noted that the patient "went to ad seg + PT got refused." Going to administrative

segregation should not be a reason to deny a medical appointment. The physician referred the patient for an American Disabilities Act (ADA) evaluation.

On 8/15/12, a physician assistant (PA) performed an ADA evaluation. The PA listed chronic low back pain, cervical pain and left rotator cuff repair as problems. These problems had not been previously listed in the previous physician notes. The PA noted full range of motion of the neck, some limitation of motion of the lumbar spine without abnormal straight leg raising, which identifies nerve compression from lower back disc protrusion. The assessment was low back pain with moderate-severe degenerative disc disease without radiculopathy. The PA wrote a disability placement program verification indicating that the patient had mobility impairment but that this did not impact placement and that the patient could function with a cane. He was given a low bunk and lower tier housing restriction. On his classification, he was listed as requiring outpatient care with infrequent consultation, was designated as able to perform limited duty and was low risk medically.

Generally, pain of this magnitude is handled by non-steroidal medication. Opioids are not typically recommended for long-term chronic pain. Effectiveness of opioids for chronic back pain is not clear. In a systematic review[78] of opioid treatment for chronic back pain, the reviewers conclude that, "Substance abuse disorders are common in patients taking opioids for back pain and aberrant medication-taking behaviors occur in up to 24% of cases." This patient was on a high dose of morphine for a condition that did not typically require morphine. He was seen repeatedly by physicians but did not have a history, physical examination, functional assessment, psychological assessment or clear indication establishing use of a narcotic analgesic for his pain particularly in the doses prescribed. This was consistently poor care over a two-year period.

On 11/4/12, an officer found the inmate in possession of a bag of white powder. The nurse documented a discussion with the inmate, who admitted that the bag contained tramadol, a narcotic prescription medication. The powder was not tested. The patient did not have a prescription for tramadol. The next day the patient asked to speak with a physician before the physician made a decision about what had occurred. He told a nurse, "I was caught in the middle passing something that I got caught with." The issue of diversion was never discussed by the physician with the patient. This is terrible communication.

On 3/22/13, the patient was transferred to CCI. Upon transfer to CCI, the patient's morphine dose was cut in half without a physician evaluation. The patient was then on 90 mg of morphine. When first seen on 4/15/13, the physician at CCI noted that the patient had filed an appeal complaining that his morphine dose was decreased. The history was not thorough. The physician documented a normal neurological examination, normal muscle tone, no muscle atrophy and a normal straight leg-raising test. The physician changed the morphine to 30 mg of extended release twice a day.

[78] Martell, BA, O'Connor PG, et al; Systematic Review: Opioid Treatment for Chronic Back Pain: Prevalence, Efficacy and Association with Addiction, Ann Intern Med 2007; 146(2): 116-127.

This sequence of care illustrates a common problem in pain management of addressing chronic pain, particularly in patients who are diverting medication and may have substance abuse disorders. Given that this patient was prescribed a high dose of narcotic medication for over two years, it is likely that if the patient did not already have a substance abuse disorder, the prison physicians promoted or may have caused a substance abuse disorder in this patient. There was no effort to attempt treatment of his pain with other modalities. The physical therapy ordered for the patient did not take place because he was housed in administrative segregation. Other measures of pain management suggested by the physical medicine consultant were not tried. When the patient exhibited behavior consistent with diversion of narcotics, medical staff ignored the problem and did not document or attempt a discussion with the patient of a better treatment plan. This was very poor care.

Pharmacy and Medication Administration

Methodology: We interviewed Tony Tran Pharmacist-in-Charge (PIC), nurses who administer nurse-administered medications and keep-on-person (KOP) medications, toured the pharmacy, clinic and KOP medication rooms, and reviewed medication administration records in each of the clinics and in health records.

Pharmacy

Findings: We found significant concerns related to pharmacy services that involved medical-legal practices that increased the risk of harm to patients. These concerns include:

- pharmacy staff renewing and changing the duration of medication orders without review and signature of an authorized medical provider;
- physicians writing orders for pharmacy staff to taper narcotics and other medications without including all elements of a legal medication order (e.g., dosage, duration, etc.); and
- pharmacy staff independently substituting formulary medications for nonformulary medications without a physician order.

Our review of health records showed a systemic practice of pharmacy staff renewing medication orders for newly transferred patients without those orders being reviewed and signed by an authorized medical provider. The current practice is that when a patient arrives, an SVSP nurse[79] prints a medication reconciliation form and checks renewal of all medical and mental health medications. The nurse faxes the form to the pharmacy without a medical or mental health provider reviewing and signing the form. The pharmacy then renews all medications for 30 days under the authorization of the medical provider at the previous facility.

[79] We presume it is a nurse that checks boxes on the medication reconciliation form to renew medications because it is done at the time of intrasystem transfer; however, the forms are all unsigned.

We believe this practice is illegal and dangerous.[80] Moreover, we found this practice to be unnecessary because patients usually arrived with valid medication orders which allowed time for providers to review and renew medication orders. We discussed this with pharmacy and nursing leadership, who indicated that issues with physicians not renewing medications timely led to the process of bypassing physicians in order to provide medication continuity. The PIC agreed to change the practice immediately.

As noted in the intrasystem transfer section of this report, we found that physicians discontinue medications without clinically evaluating or discussing treatment changes with the patient. Physicians also write medication orders for the pharmacy to taper medications without writing an order specifying the duration of the taper. In addition to the patient described in the intrasystem transfer section of this report, we found the following case: On 6/20/13, without seeing the patient, a physician wrote an order for the pharmacy to taper the patient's gabapentin when it expired on 9/26/13.[81] The physician did not examine the patient, discuss the medication change with the patient, or provide the pharmacy direction regarding how quickly the medication was to be tapered. The physician's order to taper medications does not contain all elements of a legal order. Moreover, given that the physician did not evaluate the patient, the rationale for continuing the medication until the end of September and then tapering the patient off the medication remains a mystery.

We also found that the pharmacy substitutes formulary medications for non-formulary medications without a physician order, which in one case resulted in a medication error. In the case discussed above of the 47-year-old patient[82] with high cholesterol who arrived at SVSP on 10/12/12, the patient had been prescribed simvastatin 20 mg daily. Dr. B. wrote an order for Lipitor (atorvastatin) 20 mg. daily. Atorvastatin is a non-formulary medication, so pharmacy staff changed the order back to simvastatin, but at a much higher dosage (80 mg). This dosage carries an increased risk of myopathy[83] and the drug manufacturer recommends limiting the dose to equal or less than 40 mg per day accompanied by close monitoring for myopathy, which did not occur.[84] This medication dosing error went unnoticed and was continued for six months until 4/3/13, when another provider reduced the simvastatin dosage to 40 mg per day.[85]

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[80] We believe this process is illegal because the pharmacy is changing the duration of the medication order without approval of the provider who wrote the order. In some cases, the duration of the medication is shortened and in some cases it is lengthened. Conversely, we believe it would be legal for the pharmacy to transfer the existing order as is, pending review and renewal by an SVSP provider.

[81] Intrasystem Transfer/Sick Call Patient #1.

[82] Chronic Disease Patient #10.

[83] Myopathy is muscle disease. Myositis is muscle inflammation that causes muscle pain and in severe cases can release substances into the blood stream that may cause acute renal failure.

[84] Simvastatin. Federal Drug Administration package insert. UpToDate.

[85] We discussed this case with the PIC and asked him to look into the matter. He brought us a copy of the 10/31/12 medication reconciliation form upon which Dr. B. wrote the original order for Lipitor 20 mg. On this form, pharmacy staff has written D/C (discontinue) in front of the order for Lipitor and added a telephone order for simvastatin 40 mg every evening for one year. This telephone order was not signed by Dr. B. and this amended medication reconciliation report is not in the eUHR. The

For another patient, on 1/14/13, a provider wrote an order for Omeprazole 20 mg x 14 days.[86] The following day the pharmacy filled it for 30 days.[87]

With respect to renewal of medication orders, on Monday of each week SVSP pharmacy services prints out a list of medications that will expire within 14 days. The list is forwarded to providers who are expected to review the list and renew chronic disease medications to ensure continuity of medications.

We reviewed the April 2013 AMAT report that showed that in only 48% of cases did patients receive their chronic disease medications in the previous 90-day period. Staff provided us a May 2013 Medication Expiration and Renewal Tracking Summary report that showed 184 of 184 (100%) psychotropic medication orders were either renewed and/or discontinued. It also showed that 226 of 355 (64%) medical medication orders were renewed or discontinued, and 127 (36%) orders expired.[88] These data indicate there are problems with the timely renewal of chronic disease medications.

We found examples as well. In one case, the patient's medication expired on 6/22/13, the provider renewed the patient's medication on 6/21/13, but the medication reconciliation form was not faxed to the pharmacy until 6/24/13.[89] In another case, a patient was being followed by the rheumatologist for myopathy.[90] The rheumatologist ordered methotrexate to be administered weekly. However, the medical providers did not ensure that the patient was referred back to the rheumatologist and the patient's methotrexate order expired in May 2013.[91]

Staff identified barriers to compliance as being related to a high volume of bridge orders, no lead person to take charge, and on-the-job training (OJT) for nursing staff regarding the renewal process.

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presentation of this medication reconciliation form raises questions about its authenticity. Even if the document is authentic, the pharmacy made an error by prescribing 80 mg rather than 40 mg, as the telephone order was written.

[86] There is a line that extends through the box to indicate renewal through the 1/14/13 date, possibly indicating that the provider was crossing out the 14 days, but the provider did not cross out the 14 days and then initial it to indicate that it is an error.

[87] Intrasystem Transfer Patient #16.

[88] We anticipate that some medication orders should expire, such as antibiotics, and not be viewed as a lapse in care. We asked staff if the data included lapsed medications that should have expired as well as those that should not have expired, and were told that the lapsed medications were those that should have been continued. We did not independently verify this information.

[89] Intrasystem Transfer/Sick Call Patient #7.

[90] Intrasystem Transfer/Sick Call Patient #4.

[91] On 5/3/13, the Chief P&S saw the patient for an ADA consultation in which the provider felt that his back pain was not consistent with sciatica, and that his elevated CK of the MM subtype was not consistent with myositis. He recommended an EMG, lower extremity MRI and possible muscle biopsy. This report was dictated and transcribed on the day of service and received on 5/21/13. The Chief P&S completed an RFS for an EMG and nerve conduction studies. However these studies were not completed and he received no further follow-up. Off methotrexate, the patient's CK has continued to increase to 905 on 6/5/13.

Medication Administration

Findings: We toured clinic and medication rooms in Level IV Special Needs Yard (SNY) and general population yards and the administrative segregation unit.

In the Level IV SNY, we noted that there is no overhang over the medication windows to protect inmates from the elements when receiving medications. As noted in other reports, it is unreasonable for inmates to wait in the medication line in inclement weather to receive medications. This is one of the Access Measures Audit Tool (AMAT) indicators (#9C) assigned to custody for compliance.

Sanitation in the medication room was poor, and the clinic was cluttered and disorganized. The sink did not work. The refrigerator containing food was dirty. The medication refrigerator was clean and contained large quantities of liquid gabapentin. Staff reported that liquid gabapentin was used instead of pills because of concerns about inmate hoarding and diversion of the medication.

Staff reported that there are frequent fights and lockdowns in the yard that require nurses to deliver medications in the housing units. Staff has makeshift equipment to store medications for transport. Nurses were noted to pre-pour medications from properly labeled containers into improperly labeled coin envelopes that contained both loose pills and/or unit dose medications. This is unsafe and not consistent with standards of nursing practice.

In the Level IV general population yard, there also was no overhang over the medication windows to protect inmates awaiting medication administration from the elements. On the day of the tour, nurses were required by custody to go to the housing units to deliver medications. Staff explained that there was an incident in one housing unit, and even though the other housing units were fenced off, the whole yard was locked down. Nurses had pre-poured medications and we noted that one of the nurses documented administration of medications before administering medications in the building. To document administration of medications before administering the medication is not consistent with standards of nursing practice. When nurses document medication administration prior to administering it to the patient, it raises serious questions regarding the credibility of the MARs.

In the ASU (D-2) there is a clinic but no medication room. The clinic room has a sink, exam table, privacy curtain and Snellen visual acuity chart. It had a wall-mounted otoscope but it had no power cord. There is a cage where inmates are placed for health care staff to interview. Staff reported that the room is shared with custody and we noted paperback books, a blanket and a pair of socks were maintained in the room. It appears that the clinic is used as a place for custody to relax in. There are several offices in the ASU that are used by custody and mental health for conducting daily operations, but no medication room or dedicated clinic room in the area. We recommend that this be established.

Review of medication administration records for nurse-administered medications show that they are generally legible. We did find MARs with blank spaces in which the nurse did not document the status of administration of the medication. One patient prescribed risperdal every evening had 8 of 31 blank spaces for the month of May 2013. The MAR also showed 3 of 31 blank spaces for citalopram that was to be administered every morning.[92] SVSP Yard Medication Administration and Documentation Summary Reports for the month of April 2013 in B yard showed 69.2% compliance for nurse-administered medications.

Review of Keep on Person (KOP) MARs show that nurses do not consistently document delivery of each KOP medication to the patient. For example, if the pharmacy has dispensed five KOP medications for the patient, the nurse may initial administration of one KOP medication and then put large parentheses around the other medications. In some cases, nurses have the patient sign the MAR to reflect receipt of medications, but the patient does not sign or initial each medication; instead, there is one large, sometimes illegible signature across the page. These practices do not clearly document the administration of each medication.[93]

SVSP Yard Medication Administration and Documentation Summary Reports for the month of April 2013 in B yard showed 90.9% compliance with documentation requirements. In May 2013, compliance was 42.9%. Staff-identified barriers to compliance included MARs not being in the eUHR; the front page of the MAR being scanned but not the back page; Golden (temporary) MARs being handwritten and prone to incomplete information; lack of a local operating procedure for returning MARs that need correction; late MARs received by health records; decreased staff and increased work load in health records (SVSP health records has taken over scanning of MARs from the records center in headquarters); lack of local operating procedure for sending MARs to health records; and nursing shortages in the yards.

Laboratory/Radiology

Methodology: We interviewed laboratory and radiology staff, tracking systems and health care records.

Findings: We found that there were problems with timely provider review, signature and dating of laboratory and radiology reports. This is further described under Health Records.

Health Records

Methodology: We toured the health records unit, interviewed health records staff, reviewed health records staffing and the health records (eUHR) for organization, ease of navigation, legibility and timeliness of scanning health documents into the health record.

Findings: CDCR has migrated statewide from a paper record to an electronic Unit Health Record (eUHR). This has been described in previous reports and will not be duplicated in this report.[94]

[92] Intrasystem Transfer/Sick Call Patient #19.
[93] Intrasystem Transfer/Sick Call Patients #2, #10.
[94] See Court Experts San Quentin report. March 2013.

However, we continue to support the Receiver procuring a true electronic health record, which will dramatically improve communication between health care staff, reduce opportunity for medical errors and improve the efficiency of health care service delivery.

Health Records Space and Operations

The health records space is of adequate size. Although generally clean, there is room for improvement in sanitation that we discussed with the health records supervisor. Staffing consists of 10.5 positions: The health records supervisor, which is filled; 5.5 health record technicians (HRT I positions, all of which are filled); and 4.0 office assistants (OAs), one of which is filled and three of which are vacant.

Timeliness of Scanning Health Documents

There are five stations to scan documents into the health record. Logs of beginning and end of day scanning volumes showed that on 6/5/13, approximately 21 inches of records were received to scan [Were they actually scanned or just received to scan?] into the eUHR. We reviewed a sample of laboratory reports that were pending scanning into the eUHR. [It might be helpful to comment on whether you noticed any errors.]All paper health records have been forwarded to central records in Sacramento.

Timeliness of Provider Review and Signature of Health Documents

We found wide variability in provider review and signature of health documents. In many cases, providers illegibly initial reports and do not use a name stamp.

With respect to laboratory reports, we found many that were reviewed in a timely manner. However, we also found normal and abnormal laboratory reports that physicians did not review and sign for 5-12 business days. Examples include the following laboratory reports:

- An abnormal HIV viral load of 756,065 that was reported on 5/21/13 and not reviewed until 6/5/13 (12 business days).[95] [
- An abnormal thyroid-stimulating hormone value of 6.53 that was reported on 5/24/13 but not signed until 6/5/13 (10 business days).[96]
- An abnormally high INR of 3.6 that was reported on 5/29/13 but not signed until 6/5/13 (five business days).[97]
- An INR of 2.6 that was printed on 5/30/13 but not signed until 6/5/13 (five business days).[98]
- A urinalysis showing occult blood that was reported on 5/30/13 but not reviewed until 6/5/13 (five business days).[99]

[95] Laboratory Patient # 1
[96] Laboratory Patient #2
[97] Laboratory Patient #3
[98] Laboratory Patient #4.
[99] Laboratory Patient #5

While we are not aware of any adverse outcomes with respect to delayed review of these laboratory reports, these findings raise concerns regarding systems for the timely review of laboratory reports, particularly those that are abnormal.

However, there does not appear to be a system for providers to legibly sign and date specialty services and hospital reports. Examples include the following:

- On 4/30/13, a patient with fever, cough, hemoptysis and positive tuberculin skin test had a chest CT that showed improving multilobar pneumonia. A provider has not legibly signed and dated this report.[100]
- On 3/1/13, a rheumatologist dictated a report for a patient with polymyositis. The report was received by health records on 3/11/13. A provider has not legibly signed and dated this report.[101]
- On 4/11/13, a CT scan showing bilateral cervical adenopathy including a 3-4 cm neck mass with lymphoma and metastatic disease in the differential diagnosis. The report was received on 4/15/13. A provider has not legibly signed and dated the report.[102]

Later in the report we describe other examples of hospital and/or consultant reports that were either not in the record or not reviewed and addressed by a provider in a timely manner, if at all.

An adequate health records system should ensure that providers review and legibly date and sign all laboratory, diagnostic, specialty services, and hospital reports in a timely manner. This is not occurring at SVSP.

We found instances where providers evaluated patients but did not document an entry in the health record. For example:

- On 4/17/13, a 32-year-old presented to the clinic with chest pain. A nurse initiated but did not complete an evaluation documenting that Dr. M. evaluated the patient; however, no clinical evaluation by Dr. M. is documented.[103]
- On 3/18/13, a 56-year-old with a history of stroke, left-sided weakness, and cerebral artery aneurysm experienced headache, dizziness and mouth twitching. First responders arrived at the scene and transported the patient to the TTA. A nurse performed an assessment and documented that Dr. P. evaluated the patient; however, the physician did not document a clinical evaluation of the patient. The patient was transported to an outside hospital.[104]

[100] Intrasystem Transfer/Sick Call Patient #15.
[101] Intrasystem Transfer/Sick Call Patient #4.
[102] Intrasystem Transfer/Sick Call Patient #4.
[103] Intrasystem Transfer/Sick Call Patient #15.
[104] Intrasystem Transfer/Sick Call Patient #16

We found documentation that suggested discrepancies regarding when events occurred versus when they were documented as taking place. The following case is illustrative:

On 6/3/13 at 6:18 p.m., a 51-year-old patient with an extensive history of heart disease presented to the TTA with crushing chest pain unrelieved by three nitroglycerin tablets. A nurse implemented an acute coronary syndrome protocol (e.g., oxygen, IV and aspirin) and at 7:08 p.m. the nurse sent the patient out to Salinas Valley Hospital. There is no documentation that a physician was notified at the time of the emergency. The patient returned the same evening and at 11:15 p.m. the nurse saw the patient in the TTA. On 6/3/13 at 7:55 p.m., Dr. B. documented a provider telephone note that an RN notified him that the patient was sent out to the hospital. In the same note he also documented that the patient retuned from the hospital to the facility with negative cardiac enzymes (e.g., troponin) and serial EKGs. However, the patient was still at the hospital when the note was dated and timed and the information would not have been available until the patient returned at some time after 11:15 p.m.[105] The note indicates that the physician had the information when he documented the note at 7:55 pm, which is inaccurate.

Urgent/Emergent Care

Methodology: We interviewed health care leadership and staff involved in emergency response and toured the Triage and Treatment Area (TTA). We reviewed nine charts of patients who had been hospitalized for urgent problems.

Emergency Department/Hospitalizations

Findings: We note that in the OIG Cycle 3 report, Urgent Services at SVSP had a weighted score of 92% for Urgent Services, which is not consistent with our findings. The OIG questions mostly focus on compliance issues, such as whether a patient was seen five days after discharge from a hospital, whether a patient was sent to the correct housing appropriate for their condition, or whether a TTA RN completed a face-to-face assessment upon return from a hospital. Our evaluation found inadequate urgent care related to clinical issues that were not covered in the OIG's review.

It did not appear that there were delays in getting patients to a hospital once they were identified as ill. However, there were many problems identified through review of urgent care visits. Urgent evaluations at this facility often resulted from lack of primary care management; instead of managing patients in primary care, patients were often managed through TTA visits. Often nurses performed urgent evaluations and patients were sent directly to a hospital without a physician visit or consultation. There were some judgment errors by nurses in evaluating urgent conditions. There were many instances of mistakes in transfer of information from hospitals back to physicians at SVSP. Even though the OIG scored SVSP as 100% on the question of whether nurses documented review of the inmate's discharge plan, we found that

[105] Intrasystem Transfer/Sick Call Patient #5.

physicians, in several cases, saw patients for their five-day hospital follow-up and had no record from the hospital and therefore did not understand what had taken place at the hospital, resulting in poor care.

In addition, many physician TTA urgent evaluations had substandard history, physical examination, assessments and therapeutic plans. This deficiency was confirmed also by CCHCS mortality reviewers who have cited these same clinicians. One physician who mostly works in the TTA has been cited on numerous occasions for inadequate history, physical examinations and assessments which have resulted in peer review and monitoring. We have noted deficiencies in his care throughout this report. One frequent deficiency of this physician is failure to take appropriate history and perform appropriate examination of patients with chest pain, a problem frequently seen in the TTA. We note that these types of care issues, including quality of physician care in the TTA, are not evaluated by the OIG, possibly accounting for the discrepancy between our scores.

There were also problems with physician documentation of urgent evaluations. In several cases, patients requiring emergency evaluation were evaluated by nurses who documented that a physician evaluated the patient and recommended transfer to a hospital and yet there was no evidence in the eUHR of a note by the physician. All physician evaluations must result in a documented note.

There were also many preventable hospitalizations. Mostly, these were preventable because of a lack of primary care management of the patient or substandard clinical care of the patient. This pointed out the inadequate primary care management occurring at this facility. Several examples are listed below.

One 76-year-old patient[106] had a problem list documenting cardiomyopathy with heart failure, cardiac pacemaker, seizure disorder, asthma, coronary artery disease, hypertension, high blood lipids and degenerative disc disease. He had a colonoscopy in 2008 indicating a tubular adenoma with severe atypia and a one-year follow-up colonoscopy was recommended. He also had an endoscopy in 2009 indicating esophageal stricture, esophagitis and gastritis. Neither of these two latter problems was on the problem list and follow-up colonoscopy did not occur.

On 9/29/11, the patient had two of three stools positive for blood and had hemoglobin of 11.5. There was no follow-up. The next scheduled physician visit was 1/6/12, but was not completed because the eUHR was malfunctioning. The next physician appointment was 3/19/12, and he failed to address all the patient's problems. The physician appears to have misclassified the patient's chronic lung disease as asthma. The physician noted the positive occult blood tests but documented that the patient had hemorrhoids. The basis for this was not clear. The

[106] Hospital Patient #1.

physician did not initiate an evaluation of the occult bleeding. The prior colonoscopy was not reviewed even though it was available in the eUHR.

On 5/16/12, repeat hemoglobin was reported as 10.5. This test result was signed as reviewed but no work up ensued, even though the patient was on Plavix. Plavix can cause bleeding and anemia, and a patient on Plavix with anemia is a cause for concern. The patient needed an immediate evaluation and possibly discontinuation of the Plavix. On 6/19/12, the patient had rectal bleeding for a week. A TTA physician addressed the issue by phone noting that the patient was on Plavix and aspirin and had positive occult blood with a "? distant hx (history) of rectal polyp." A follow-up was ordered.

The patient was seen for this follow-up on 6/21/12. The physician noted that no record was present but documented that this was a follow-up of the TTA visit. The physician noted that a colonoscopy had been done two years previous and no cancer was identified (a pre-cancerous lesion had been identified). The physician examined the rectum and noted hemorrhoids and concluded that the patient had bleeding hemorrhoids. Repeat stool testing for occult blood and another blood count were ordered. The physician did not address the fact that the patient was on Plavix or aspirin or identify why the patient was on these medications and did not refer the patient for gastroenterology evaluation. Patients with anemia and gastrointestinal bleeding need a timely work-up and the indication for Plavix needs to be immediately evaluated; this was not done. The presence of hemorrhoids in a 76-year-old with occult bleeding and anemia still requires a colonoscopy and upper endoscopy, especially in light of his being on Plavix. This was substandard care.

The three follow-up occult blood tests were all positive and the hemoglobin test was now 10.4. The tests were signed as reviewed but no referral took place. On 6/25/12, the patient was hospitalized for a kidney infection and was seen in follow-up at the prison on 6/29/12. The recent abnormal hemoglobin and positive occult blood tests were not noted. This was another example of failure to follow-up on abnormal test results and substandard care.

On 7/16/12, the patient had a fever of 103.1°F. The physician's history did not include any of the patient's medical conditions. The physician documented that the patient had a remote history of malaria and sent the patient to the TTA for a urine culture and a malaria test. There was no mention of the patient's anemia, occult bleeding or any of his other medical conditions. The history was extremely brief. To consider a likely cause of the patient's fever to be malaria, based on a possible remote history, is suspect clinical judgment. In the TTA, the patient received IV fluid and had more blood tests ordered for the morning with a primary care follow-up. Notably, the malaria test was not ordered. The physician ordered an antibiotic for a urinary tract infection. The patient was not admitted to the CTC, but this should have been considered given his age and multitude of medical conditions.

The next day a provider saw the patient but performed a very poor history and physical examination. The physician wrote that he would wait for the laboratory tests and follow-up. On

7/18/12, the patient had fever of 101.3°F. Another physician saw the patient, but aside from documenting a cough, no history was taken. The physician documented a normal examination, failing to note the patient's prior abnormal laboratory tests. The physician diagnosed bronchitis [and?] but sent the patient to the TTA. However, the TTA physician had already left but the nurse notified the physician by telephone. The history obtained was inadequate, documenting only that the patient had a prior urine infection, a dry cough, and was already on an antibiotic. The TTA physician diagnosed the patient with a urinary infection and sent him back to his housing unit. None of the laboratory tests ordered on 7/16/12 was evaluated. These tests revealed a decrease in the patient's hemoglobin to 8.4. Even though these tests had been for a next day follow-up, they were not signed as reviewed until 7/23/12. Despite the alarming drop in the patient's hemoglobin, there was no follow-up of the abnormal tests. This continued failure to follow up on abnormal tests placed the patient at considerable risk of harm, as he was on a blood thinner and had documented blood loss.

The patient was next seen 7/19/12 in primary care, and the physician noted that the patient had fever since 6/23/12, which was almost a month. The patient did not have a fever at this visit. The physician did a thorough evaluation and noted abnormal lab results. The stool was negative for blood. A blood count and iron studies and BNP were ordered. A gastroenterology consult was finally ordered to evaluate the anemia. A 3-day follow-up was ordered.

On 7/31/12, endoscopy was done, 10 months after the patient first had a positive occult blood test. The patient was noted to have a large gastric ulcer suspicious for malignancy. The gastroenterologist recommended stopping the Plavix to prevent bleeding. The biopsy was stamped as received 8/1/12, but there was no action taken at the prison to follow up on this abnormal pathology test except a phone order from the TTA to stop the Plavix. This was inadequate follow-up of a significant abnormal test.

On 8/11/12, without an intervening physician evaluation, the patient had respiratory distress with a pulse oximeter[107] reading of 78%. He was rushed to the hospital where he was found to have sepsis. After treatment of the sepsis, adenocarcinoma of the stomach and esophagus was diagnosed. Later in April 2013, the patient was also diagnosed to have rectal cancer. He ultimately died from these two conditions.

This record review showed consistent substandard care and consistent failure to follow up on life threatening conditions. Failure of primary care management resulted in frequent and inadequate TTA management, hospitalization and ultimately a delayed cancer diagnosis.

Another patient[108] had obesity, diabetes mellitus, a prior stroke with subsequent neurogenic bladder and an implanted suprapubic catheter, a right foot amputation due to diabetes,

[107] A pulse oximeter is a method of measuring the oxygen saturation of the blood. Normally, it is > 95%. Results < 90% require immediate evaluation.
[108] Hospital Patient #3.

hypertension, hypothyroidism, a seizure disorder, high blood lipids and prior coronary artery disease with three prior stents. The patient was continuously documented as having Niemann-Pick disease, a rare genetic abnormality. This was documented on the Problem List and on patient care visits even though a gastroenterologist documented that the patient did not have a clinical presentation consistent with Niemann-Pick disease. This was significant because the patient had high blood lipids that facility physicians ascribed to Niemann-Pick disease. The gastroenterologist instead recommended better control of his diabetes, which he said was contributing to his high blood lipids.

This patient had six hospitalizations between 6/1/12 and 12/1/12. In none of the hospitalizations was the patient seen by a physician prior to being sent to the hospital. These repetitive hospitalizations were often for chest pain, but the ultimate reasons for hospitalization were not subsequently addressed by the primary care physician after return from the hospital.

Over the six-month span of our chart review, the patient's blood pressure was not in control but medication was not adjusted. On several occasions, physicians documented that the blood pressure was in control when it was not. On several occasions, physicians documented that the blood pressure was not at goal but did nothing to modify therapy. On two occasions, when the patient saw outside cardiologists, the blood pressure medication was recommended to be increased by the cardiologist but SVSP physicians did not act on those recommendations. This is indifferent and substandard care.

Over the six-month span of our chart review, the patient's diabetes was not in control and only minor adjustments were undertaken to modify therapy. At chronic care visits, physicians did not take an adequate history to determine diabetic control and adjust medication. At times, physicians documented that the diabetes was in control when it was not. A hemoglobin of 7.7 was taken as "at goal" when this is not in control. Blood sugars were consistently between mid-200 levels to 400. The uncontrolled diabetes caused continual harm to the patient and additionally affected his lipid control, especially the triglycerides. Diet, exercise and weight control were not addressed. The blood triglycerides were extremely high on most tests, including one value of 715. This was directly affected by diabetes control which was extremely poorly managed. A consultant documented that the patient needed better control of his diabetes to help control this abnormality. This was not done. The high triglycerides placed the patient at risk for pancreatitis. The patient had developed a fatty liver. This was most likely attributable to the uncontrolled diabetes and high blood triglycerides. The patient's diabetes care was substandard.

Primary care visits did not cover all of the patient's medical problems, histories were never adequate, physical examinations were poor and assessments only addressed the current complaint of the patient. This reflected episodic care.

The patient was on over 20 medications on a keep-on-person basis. These included two anticoagulants (Plavix and warfarin), which can have life threatening side effects. There was no evidence that physicians discussed medication use with the patient to ensure that the patient

was taking his medications correctly. Also, it is not clear from notes that physicians knew all the medications the patient was taking visit to visit because medication management for all of the patient's conditions was not discussed at primary care visits. This is not in keeping with the CCHCS primary care model and is substandard care.

The patient had a neurogenic bladder from his old stroke. He had a suprapubic catheter and this was repeatedly colonized.[109] During chronic care visits, the patient did not have thorough histories or evaluations about care of his indwelling catheter. Because the urine was repeatedly cultured positive, the patient was on almost continuous antibiotics even though colonized urine is common in this condition and treatment with antibiotics might be fruitless. The patient did have several hospitalizations with kidney infections, yet attention to the hygiene issues related to catheter colonization were not addressed. The patient was not well informed of the consequences of an indwelling catheter and it appears that the physicians were not aware either. Also, the patient repeatedly grew fungus in his urine, probably a result of his uncontrolled diabetes. There was no documentation of a thorough attempt to manage this condition via a collaborative treatment plan with nursing and a urology specialist.

Another patient[110] had severe sickle cell disease with several complications, including splenectomy, leg ulcers, cardiomyopathy, hemochromatosis[111] from repeated transfusions and a prior cholecystectomy. All of his conditions were attributable to his severe sickle cell disease. On multiple episodes of care spanning from April 2012 until December of 2012, physicians at SVSP consistently failed to adequately evaluate his pain. Typically, histories of pain were inadequate. Use of breakthrough medication[112] was not documented. Pain medication was at times increased or decreased without examination or seeing the patient. There was no monitoring of as needed medication use. Despite bona fide episodes of sickle cell pain crises, staff at times suggested patient manipulation. His pain management was callous and indifferent to his needs.

Over the six-month span of chart review, the patient had five hospital admissions for sickle cell crisis, yet the patient did not have a clear pain management strategy in place. During one hospitalization, a hospital physician documented,

> "Patient believes that he is being thought of as a drug seeker, where he is not drug seeking, it is just that the regimen that he has been given has been unable to control his

[109] Patients with indwelling catheters frequently have bacteria grow in the bladder, called colonization. Colonization typically does not indicate serious infection and is without other symptoms; therefore, colonization by itself does not typically require treatment with antibiotics.

[110] Hospital Patient #4.

[111] Hemochromatosis is a condition of increased iron in the body. This can result from repeated transfusions. Excess iron can infiltrate and damage multiple organs.

[112] Breakthrough medication is short-acting pain medication given on an as-needed basis to treat pain exacerbations to patients who are receiving long-acting pain medications.

pain. I advised the patient that he can ask for more pain medication, will recommend to the prison he gets more pain medication."

Another example of callous treatment occurred when the patient was urgently seen in the TTA for nausea and vomiting. No history was obtained and only a brief examination was performed, noting a soft abdomen with normal bowel sounds. The physician noted that a nurse stated that the patient was seeking injectable Phenergan, an anti-emetic. An oral anti-emetic was prescribed without attempting to further evaluate why the patient had nausea and vomiting. The patient was sent back to housing. The next day the patient again was seen in the TTA for continued symptoms. A physician on call evaluated the patient via telephone and noted that the patient had a long history of manipulation and was on methadone. There was no history attempting to clarify the nausea or vomiting. The physician again prescribed an oral anti-emetic.

Treatment with anti-emetics continued for months, but no history was taken related to symptoms and continued need for the medication and no effort was made to evaluate the source of vomiting when that symptom occurred. This was episodic, indifferent and substandard care.

Indifference was evident in multiple other episodes of care. This patient was on both morphine and methadone for his sickle cell pain. The methadone was a regular chronic medication and the morphine was for break through pain. At one point, a nurse transcribed what appeared to be a medication renewal that changed methadone and morphine to just methadone. This apparent medication error was unnoticed by physicians in multiple subsequent visits, which exemplifies the extremely poor communication with the patient regarding his pain medication. On another occasion, a physician decreased the patient's medication by half without documenting a rationale and without taking a history to support his clinical decision. On another occasion, a physician reduced pain medication by 30% without evaluating the patient. In another episode, a physician checked a skin and extremity box as "within normal limits" when the patient was being followed for long standing chronic skin ulcers. The patient had numerous complications of sickle cell disease, but on a review of systems for a CTC admission on 8/31/12, the physician checked all review of system boxes except for skin as "within normal limits." A hematologist recommended therapy for hemochromatosis, but this was not acted on for six weeks. On 11/28/12, the patient was seen in the TTA for chest pain and shortness of breath. An on-call telephone physician evaluation included an inadequate history of the patient's current complaint. The history was one line and stated "chest pain, SOB (shortness of breath), times 1 hour, aggravated by deep breathing." (For example, there was no history related to the severity, quality, or radiation of the pain.) The patient was sent back to his housing unit to be admitted to a local hospital later that same day. This evaluation was substandard.

In summary, this patient had repeated episodes of substandard and indifferent care stretching over the entire span of our chart review. These repeated deficiencies resulted in multiple

hospitalizations which were potentially preventable with proper primary care management of his sickle disease.

Another patient[113] had pulmonary cocci and was on high dose of fluconazole, an antifungal medication. Beginning in late May 2012, shortly after being sent back from the hospital, the patient experienced multiple episodes of vomiting, nausea, diarrhea and inability to eat. These often resulted in urgent evaluations but were not appropriately addressed.

On the first episode, the patient was evaluated by a nurse who obtained a phone order for an anti-emetic with no physician examination.

Abnormal laboratory tests indicating possible dehydration and other problems (sodium 130 and chloride 95, alkaline phosphatase 168 and albumin 2.8, hemoglobin 10.5, sedimentation rate 94) were done 5/19/12 but not signed as reviewed until 6/12/12.

On 6/3/12, another episode of vomiting resulted in the patient submitting a 7362 health request. A nurse took a history of vomiting for two weeks and loss of appetite and the nurse documented a five-pound weight loss. The patient had an increased pulse. The nurse documented that a physician saw the patient and ordered ranitidine.[114] There was no documented physician note, including the rationale for ordering ranitidine, which is inappropriate. The abnormal laboratory tests were not reviewed. This was substandard care and placed the patient at risk.

An infectious disease consultant saw the patient by telemedicine on 6/4/12 and noted the patient was not doing well. The patient had a pulse of 115/minute. The consultant recommended checking liver function tests, a cocci titer and an x-ray. The consultant noted that the patient had a prior knee aspiration and lumbar puncture but results from these tests were unavailable. This was one of many episodes in which prior tests results were unavailable to clinicians seeing patients.

On 6/6/12, the patient was emergently evaluated for fever and vomiting. His pulse was elevated (112/min). The patient was sent to a local hospital where his knee was aspirated again because it was swollen. Tests of the fluid were negative. The patient was treated for dehydration and returned to the prison. When the patient was seen upon return, the physician documented that the chart was not available because the eUHR was down. The physician did not take a medication history.

On 6/15/12, a nurse evaluated the patient because of a 7362 health request for joint pain and weakness. The patient had a temperature of 101°F and a pulse of 120/min. The patient needed a wheelchair to get to the clinic. The nurse documented that the patient was “reluctant to go to

[113] Hospital Record Patient #5.
[114] Ranitidine is used to treat ulcers and reflux disease.

ER now," and the patient was sent back to his housing unit with a bottle of Tylenol. This was inappropriate and dangerous, as the patient required urgent evaluation.

Five days later on 6/20/12, the patient placed a 7362 that stated that his toes and legs were swollen and that he could not walk. The nurse documented at the bottom of the 7362 that the request was triaged on 6/21/12. There was a comment that the patient was on the MD line for 6/22/12. This was an urgent problem and should have been addressed immediately.

A physician saw the patient on 6/22/12 for joint pain. The patient had a fever of 100.4° F and complained of fever, chills, but no shortness of breath. His pulse was 111/minute and blood pressure was 96/68mm/Hg, but orthostatic vital signs[115] were not taken. He did not have nausea, vomiting or diarrhea. His weight was not taken. The history was poor. Laboratory results were not reviewed. The physician assessed the patient with joint pain, disseminated cocci, fever and tachycardia and sent the patient to the hospital. The patient refused hospitalization stating that they were "not listening to me."

Although the patient refused hospitalization, he should have been housed on the CTC or seen daily in primary care because he was very ill. Instead, the patient was sent back to housing without scheduled follow-up. The patient, who was seriously ill enough to require admission to the hospital, was not seen for four days. On 6/26/12, the patient placed a 7362 because he had diarrhea and could not walk. Ultimately, the patient was seen by emergency responders. On the 6/26/12 visit, he had a fever of 100.2°F with a pulse of 103/min. He was described as too weak to stand and had a weight of 130 pounds, indicating that he had lost approximately 30 pounds over the prior month. A physician saw the patient and documented a weight of 130 pounds with repeated vomiting. The patient was transported to a hospital. It was below standard of care to send a patient who needed hospitalization back to population without follow-up. This was dangerous, negligent, and placed the patient at risk of harm. At the hospital, the patient had signs of dehydration and possibly malnutrition.

When the patient returned from the hospital on 6/30/12, despite his serious condition when sent to the hospital, he was not seen for five days. At that visit, on 7/5/12, the physician noted that the hospital record for the patient was not available. There was no medication history and abnormal laboratory tests were not noted. An orthopedic consultation was ordered for the patient's continued knee swelling and a six-week follow-up was ordered. A blood count and metabolic panel were ordered. The patient needed to be rescheduled for follow-up sooner or placed on the CTC, as he had two previous hospitalizations over the past few weeks and had significant weight loss. This was substandard care. There was no history or documentation of the 30-pound weight loss and no mention of abnormal laboratory results identified at the hospital. There was no nutrition assessment, even though the patient had significant weight

[115] Orthostatic vital signs are obtained by having the patient lying down and then standing up. They are a method of assessing dehydration.

loss that might have been related to his chronic disease. His weight was not taken. There was no assessment of his cocci particularly related to medication management with fluconazole and its potential side effects. This was not appropriate.

When the laboratory results ordered on 7/5/12 were reported on 7/6/12, they were abnormal (sodium 130, CO2 20, calcium 8.3, albumin 2.6, hemoglobin 9.8 and platelets 666,000) yet were not signed as reviewed until 7/9/12 and there was no follow-up. He had fever to 100.2°F and pulse of 116/min. The patient was sent to a local hospital on 7/9/12 for disseminated cocci.

This patient had disseminated cocci. It was apparent that the physicians monitoring this disease were not competently managing his care. He was hospitalized three times over approximately a two-month period of time for dehydration, fever and failure to thrive. These episodes of dehydration and vomiting may have been due to the medication he was taking for cocci, yet the providers did not document a history that included medications. Deficiencies include: laboratory tests were not followed; medication for cocci was not appropriately being managed by evaluating for side effects; symptoms of vomiting were not evaluated; weight loss was not assessed; nutritional evaluation was not done despite a 30 pound weight loss; nurses did not refer the patient for physician evaluation when seriously ill; and the patient was severely ill and nevertheless was housed in general population instead of placement in the CTC or monitored more frequently, consistent with his disease. These hospitalizations may have been prevented with expert outpatient management of his cocci disease.

Another patient[116]transferred from Solano on 12/7/11 with a history of asthma, allergic rhinitis and chronic pain. He was on morphine, gabapentin, Xopenex and Flovent. The first physician note was 12/19/11. On the dictated note, the physician noted that the patient had a prior gunshot wound and was maintained on gabapentin and morphine. There was no other history of pain. The physician documented that the patient was using Xopenex 4-6 times a week and also using Flovent twice a day. The PEFR was not documented. No other symptoms were described. Based on this history, the physician assessed moderate intermittent asthma and ordered cetirizine, Flovent, flunisolide, gabapentin and Xopenex. The history did not have sufficient information to diagnose moderate intermittent asthma. There was no physical examination related to the arm pain except to note that there was scarring on the left upper arm. No functional or neurologic examination occurred. Based on this encounter, morphine was changed to methadone. This is a poor history. Particularly for the pain issue, the physician had not established a physical reason for the need for pain medication and the history was negligible. There was no documented rationale for use of narcotic pain medication and there was no rationale provided for changing morphine to methadone. On the handwritten initial history, the physician checked the box under neurological as within normal limits, and under musculoskeletal, abnormal was checked but the only comment was “GSW upper arm.” This is irresponsible care. The prescription of methadone without an adequate assessment is not

[116] Hospital Patient #8.

consistent with the Medical Board of California guidelines for prescribing narcotic pain medication.

The patient was subsequently not seen for more than six months. The methadone was renewed in between chronic clinic visits without any evaluation of the need for narcotic medication.

On 6/29/12, the patient submitted another 7362 stating that he had a bad cough. He said that the nurse gave him some allergy medication but that it was not working. He said the cough kept him up all night. A nurse evaluated him the same day. Asthma history was noted. The patient gave symptoms of nasal congestion and cough. The pulse was 90/minute and the blood pressure 116/75 mmHg. There was nasal congestion. The nurse did not document auscultation of the lungs but wrote "coarse" in the lung field section. The nurse did not document a nursing diagnosis and gave cough syrup. The patient was released with instructions to submit another health request if he was not better. This patient had not been seen for almost seven months and had symptoms of asthma. Despite this, the nurse did not identify this problem and did not refer him to chronic care. This is poor care.

On 7/3/12, the patient placed another 7362 stating that his methadone had expired and that he needed to see a physician. He was seen that day by a primary care physician. This visit was the first visit with a physician in almost seven months. During that visit, the patient complained of a non-productive cough for a week. The physician noted that the patient had asthma and neuropathic arm pain. The patient had coarse wheezing throughout his lungs. The physician diagnosed an exacerbation of asthma and ordered prednisone and nebulization therapy with a seven-day follow-up. Because the patient was experiencing an exacerbation of asthma, a sooner follow-up was indicated.

On 7/5/12, the patient had difficulty breathing and was emergently seen. The pulse was 124/minute with a pulse oximeter reading of 78% which indicated that his asthma is life-threatening. The patient was having trouble speaking and was using accessory muscles.[117] The patient was sent to the hospital.

At the hospital, hospital staff documented that SVSP staff had told them that the patient was suspected of using heroin and was having trouble breathing. Upon arrival at the hospital, the patient's oxygen saturation was 100% (he was receiving oxygen). The patient was given Narcan and that appeared to help, but ultimately the patient required intubation. His pulse was 132/minute with a blood pressure of 100/70 mmHg. His white count was very elevated (WBC=20.6K, normal=4-10K) and he had a low pH (7.24) on his blood gas. These values are consistent with a severe asthma exacerbation. The patient had a urine toxicology positive for opiates, methadone and cannabinoids, indicating that the patient was using opiates and cannabinoids, which were not prescription. Nevertheless, the patient was in life-threatening asthma status and needed intubation for survival. The initial chest x-ray did not show an

[117] Use of accessory muscles is a sign of severe asthma.

infiltrate. He was given intravenous steroids and nebulization. He was placed in the ICU for status asthmaticus. He was ultimately extubated and recovered. He was discharged on 7/12/12 on Singulair, gabapentin, methadone, a tapering dose of prednisone, and albuterol. The hospitalist also recommended follow-up with pulmonology, a sputum culture, cocci serology, and a total IGE level[118] to monitor for allergic Aspergillus (because the hospital staff believed that his asthma attack may have been precipitated by a fungal disease). The discharge diagnosis was respiratory failure from asthma exacerbation with mold growing in this endotracheal aspirate, indicating that the patient might have a fungal lung infection.

Upon the patient's discharge from the hospital, he was not seen for four days even though he had been intubated at the hospital. Patients with asthma who have just recently been extubated should be seen upon arrival at the prison. The patient was not seen until 7/16/12. The physician's history noted that a cocci serology needed to be done. But the physician did not understand the remainder of the recommendation and wrote "? mold culture." If the physician did not understand the recommendations of the hospital, he should have simply called the hospital physician and clarified the recommendation. This did not occur and demonstrated very ineffective communication or indifference. The physician noted that the patient had positive urine toxicology. The physician did not question the patient about asthma symptoms. The physician assessed asthma but did not give a status. He recommended discontinuation of methadone but did not document what treatment would be given for the asthma. The physician was focused on the abnormal urine toxicology screen but not on the patient's asthma, despite the recent life-threatening asthma attack. A two-week follow-up was ordered. This was not a good evaluation. The asthma was not assessed after a hospitalization for asthma that included intubation. In addition, the patient had toxicological evidence revealing that the patient was using opioids other than what had been prescribed, yet there was no pain assessment. Instead, methadone was simply discontinued without a clinical assessment and without consideration of inevitable withdrawal. Although there was no indication for methadone and it should have been discontinued, a tapering would have been more appropriate. The pulmonary consultation recommended by the hospital was not ordered, and laboratory tests recommended by the hospital were not done. The asthma care was substandard and indifferent.

On 7/27/12, the patient submitted a 7362 wanting to know why his methadone was discontinued. Although the nurse wrote "see encounter form," there was no encounter form in the eUHR. Apparently, the physician did not talk to the patient about discontinuation of his methadone. This was not effective communication and displays indifference to the patient.

The patient was seen in the primary care clinic on 8/6/12. At this visit, the only history of asthma was that the patient was using his inhaler three times a week. The steroid use and use of Singulair was not discussed. There was no discussion of a plan to manage the asthma, no

[118] IgE is an antibody that is elevated in allergic conditions.

discussion of medication management, no follow-up of the recommendation to monitor for allergic Aspergillus, no check of the total IGE levels and no follow-up of the cocci serology. There was no documentation acknowledging the need for pulmonary consultation. The physician did discuss the discontinuation of methadone. The physical examination consisted only of the physician checking the general and pulmonary boxes as within normal limits. The physician documented that the patient was intubated due to overdose, not asthma. This was not consistent with hospital records. The discharge summary definitively documented that the patient was intubated as a result of asthma. The physician scheduled a six-month follow-up. This was a cynical note not supported by hospital documentation. The six-month follow-up was inappropriate and indifferent toward a patient with recent intubation and possible fungal infection. There was no mention of pulmonary follow-up as recommended by the hospital.

The patient was not seen again until 2/13/13, six months later. The pulmonary chronic clinic note documented that the patient's last exacerbation of asthma was in July 2012 but did not document the intubation. Exacerbations were documented as rare. The physician documented no hospitalizations or intubations due to asthma, which was not accurate. The heart and lung examination boxes were checked within normal limits. Moderate persistent asthma was diagnosed. There was no change in medications. This is a very poor chronic illness evaluation. It was not consistent with the hospital diagnosis, and there was no follow-up of the hospital recommendation to have a pulmonologist see the patient.

About six weeks later, on 3/25/13, the patient submitted a 7362 for "phlegm" in his lungs and asked to see the physician for asthma. A nurse saw the patient on 3/26/13 and documented a history of shortness of breath. The patient's pulse was 109/minute. The nurse wrote that the patient was on Xopenex and Flovent. The nurse wrote that the patient was wheezing in all lung fields and had a "moist" cough. The nurse consulted a physician and apparently, based on that consultation, told the patient to use his inhaler and increase his fluids and to return if the symptoms persist. This was inappropriate care by the physician. The patient clearly had not been regularly seen and was having an exacerbation of asthma and needed to been seen.

The next day, on 3/27/13, the patient placed another 7362 for his asthma. He said that he was wheezing. A nurse wrote on 3/28/13 that the patient would be seen on the RN line but there was no documented encounter in the eUHR. On the 7362, "see encounter form" was written, but there was no encounter form in the eUHR. This was dangerous for the patient.

On 3/29/13, the patient was seen emergently for wheezing. He went to the TTA where he was noted to have wheezing. He was treated with IV SoluMedrol and oral prednisone. There were no further notes on this patient and apparently, he was not seen again until at least June of 2013 when our visit occurred. To treat a patient with intravenous SoluMedrol for an asthma exacerbation and to not evaluate the patient for months is substandard medical care. His initial hospitalization was probably preventable if the patient had received regular chronic clinic management.

Another patient[119] is a 32-year-old man who was transferred from SATF to SVSP on 7/26/12 with diagnoses of hepatitis C infection, hypertension, chronic abdominal pain and tachycardia (increased pulse) of unknown etiology. When the patient had his initial history and physical examination, the problems of tachycardia was not addressed and the "review of systems" box listed "cardio/HTN" as within normal limits. Over the next five months, the patient had repeated episodes of spontaneous tachycardia resulting in two hospitalizations. At no time during this time period did a physician at SVSP take a cardiac risk factor history in the evaluation of his chest pain. Typical history and physical examination and laboratory testing for a rapid heart rate were not done or were not timely done. After about six months, the patient saw a cardiologist for an echocardiogram. During that test, the cardiologist noted a paroxysmal tachycardia with a rate up to 140/minute. He recommended a Holter monitor[120] in January of 2013, but this test has not yet been performed.

Our review also revealed another problem related to pain management. At the initial history and physical examination, a physician prescribed Tylenol with codeine for a month without a thorough pain history or examination and clear indication. This narcotic drug was renewed three times, all without evaluation. This patient was therefore on a narcotic without any monitoring or reasonable indication.

Specialty Services/Consultations

Methodology: We interviewed staff involved in the review, approval and tracking of specialty services, OIG and other internal reports and reviewed health care records of 10 patients for whom services were requested.

Findings: We found significant problems with the system for tracking on and offsite specialty services and related reports. The previous IMSATS aging report provided staff the ability to closely monitor the timeliness of specialty services. The new MedSATS scheduling system results in reports that do not provide staff the ability to track when the service was requested, approved, scheduled, or completed and whether the service is overdue. The report format is a significant disadvantage compared to IMSAT aging reports and hopefully can be remediated. Previously, staff responsible for scheduling off-site appointments were also responsible for tracking the reports. At SVSP, this responsibility was reassigned to a nurse working in the TTA who has other duties. She reported that she tracks the return of the Request for Services (RFS) form upon which the consultant writes handwritten findings and recommendations. However, in many cases the consultant dictates more thorough reports and the TTA nurse does not know if and when dictated reports are received at the facility. We found records that did not contain dictated reports and thus not all consultant findings and recommendations were addressed.

[119] Hospital Patient #11.
[120] A portable device used to continually monitor a patient's heart rate.

This is a systems issue that places patients at risk of harm and a problem noted throughout our report.

Another concern is related to the timely follow-up of patients following outside specialty services. Staff reported that previously, when patients came through TTA following a specialty consultation, the TTA provider could write orders implementing the consultant recommendations, including clinical follow-up with the consultant. That process was changed to have the primary care provider address consultant recommendations.[121] According to staff, however, the PCP has two weeks in which to see the patient and consultant recommendations are sometimes time sensitive and need to be implemented prior to the routine appointment with the provider.

Staff also reported that previously, a utilization management (UM) approval for surgery automatically included an initial post-operative visit. The scheduling staff could automatically schedule a follow-up appointment based upon the surgeon's requested follow-up timeframe, but this was no longer the case. According to staff, now a second RFS was to be submitted for approval of the postoperative visit. This does not ensure timely care.

There were serious problems related to timeliness and/or adequacy of care in eight of the 10 records we reviewed for specialty care. Our findings are consistent with the OIG Cycle 3 report, which showed that only 50% of urgent appointments occurred within 14 days. Our findings are not, however, consistent with the finding that timely follow-up occurred in 86.7% of the cases. The May 2013 CCHCS Dashboard shows that SVSP scored only 74% with respect to timely PCP appointments following specialty services. The problems we found are discussed in the cases below.

- The patient is a 52-year-old man who saw a urologist on 4/11/13 for evaluation of retroperitoneal fibrosis.[122] The urologist recommended a nuclear renal scan to evaluate the functioning of the kidneys and to rule out obstruction. On 4/16/13, the primary care provider ordered the scan on an urgent basis. The scan was not performed until 5/23/13. The scan revealed that there was very limited perfusion and functioning of the left kidney. The primary care provider saw the patient for follow-up of the scan on 6/4/13. He noted that the patient needed follow-up with the urologist to remove the compressing mass. The patient had not seen urologist for follow-up as of 6/14/13.[123]

[121] According to staff, the TTA provider may write orders for consultant recommendations that are considered urgent.
[122] Retroperitoneal fibrosis is a rare disorder that occurs when extra fibrous tissue forms in the area behind the stomach and intestines. The excess tissue forms a mass (or masses) that can block the tubes that carry urine from the kidney to the bladder.
[123] Specialty Care Patient #2.

Assessment
The urgent nuclear scan was not performed in a timely manner. Furthermore, the patient did not have timely follow-up with the urologist for his potentially serious problem.

- The patient is a 56-year-old man with a mechanical mitral valve who saw a cardiologist on 2/28/13. The cardiologist recommended an echocardiogram and follow-up in three months or sooner. A provider ordered the echocardiogram on 3/8/13. There is no documentation, however, that he ordered the recommended cardiology follow-up. The echocardiogram was performed on 3/22/13 and revealed a dilated left atrium and the left ventricle with a reduced ejection fraction of 45%. That same day, the primary care provider sent a notification to the patient that a chronic care appointment had been scheduled to discuss the results of the echocardiogram. Since that time, the patient has been seen numerous times in Anticoagulation clinic but, as of 6/28/13, has not been seen for follow-up of the echocardiogram by either a primary care provider or the cardiologist.[124]

  Assessment
  There was no follow-up related to the patient's echocardiogram.

- The patient is a 47-year-old man with a history of sarcoidosis.[125] He was seen for specialty care by a pulmonologist on 4/15/13. The pulmonologist recommended referral to a dermatologist for evaluation of possible cutaneous sarcoidosis. The patient was not seen for follow-up of this visit by a primary care provider and was not referred to a dermatologist.[126]

  Assessment
  There was no follow-up to the specialty care visit and no documentation that the specialist's recommendation had been addressed.

- The patient is a 45-year-old man who was referred to a urologist for evaluation of a very elevated PSA (34 ng/mL; normal $\leq$ 4). The urologist saw the patient on 4/25/13 and recommended a biopsy to rule out cancer. The patient did not see a provider for follow-up of this visit and had not had the biopsy as of 6/28/13. Moreover, there was no documentation that the biopsy had been ordered.[127]

  Assessment
  There was no follow-up to the specialty care visit and no documentation that the specialist's recommendation had been addressed.

[124] Specialty Care Patient #3.
[125] Sarcoidosis is a disease in which inflammation occurs in the lymph nodes, lungs, liver, eyes, skin or other tissues.
[126] Specialty Care Patient #4.
[127] Specialty Care Patient #5.

- The patient is a 30-year-old man with hypertension requiring two medications and a cardiac arrhythmia. The cardiologist saw him on 1/22/13. The cardiologist recommended 24-hour Holter monitoring. He also recommended a special laboratory test "because of patient's relatively young age and development of hypertension requiring two agents." The primary care provider saw the patient on 1/31/13 and noted that the consultant's report was not available. He wrote an order to obtain the cardiology report and ordered follow-up in 30 days. Providers saw the patient on 2/20/13 and 3/20/13. They did not note whether the consultant's report was available and did not address the recommendations. A provider saw the patient on 4/12/13 and ordered a Holter monitor on an urgent basis. The patient refused the study on 6/18/13. As of 6/28/13, there was no documentation that a provider had been notified of the refusal or had discussed it with the patient. Furthermore, the recommendation by the cardiologist for the laboratory test had not been addressed.[128]

  Assessment

  The patient did not receive timely or adequate follow-up of his cardiology visit. In addition, there was no documentation that a provider had been notified about the refusal, and there had not been any counseling or further follow-up. Even though the patient ultimately refused the study, this case reflects common problems with specialty care follow-up that places patients at risk for harm.

- The patient is a 43-year-old man who fractured his hand on 6/12/12 at another facility. An orthopedic surgeon saw the patient on 11/19/12. The surgeon noted that the patient had previously been diagnosed with a malunion[129] fracture of the left hand, that he had been approved for surgery and that the surgery had not been scheduled. The surgeon expressed concern that the patient may have a bone infection and recommended hand surgery to fix the fracture. On 11/27/12, the primary care provider referred the patient to a hand surgeon for the recommended surgery. The patient was not seen by the hand surgeon until 4/12/13. The surgeon noted that the hand fracture was fully healed and that the patient had moderate stiffness with mild swelling. He did not recommend surgery at that time.[130]

  Assessment

  The patient was not seen by a hand surgeon for almost five months. While it does not appear that the patient suffered untoward consequences from this delay, it does demonstrate a lack of timeliness for specialty care.

- The patient is a 32-year-old man who injured his right hand in May 2012. X-rays performed at that time did not reveal any fractures. A provider saw the patient on

[128] Specialty Care Patient #6.
[129] Malunion refers to the healing of a fracture in an abnormal (nonanatomic) position.
[130] Specialty Care Patient #7.

9/25/12, and noted that the patient was still complaining of pain and that his finger was swollen. The provider ordered an x-ray to rule out an occult fracture. The x-ray was performed on 9/27/12 and was compatible with a volar plate fracture.[131] The same day, a provider sent the patient a notification that he was being scheduled for a follow-up medical appointment to discuss his x-ray results. This did not occur. The patient saw a provider on 10/13/12 for another problem and asked the provider for the results of the x-ray. The provider noted the results of the x-ray and referred the patient to a hand surgeon for follow-up. The patient submitted a medical care request on 11/18/12, stating that his finger was broken and he was in severe pain. He added that he was not receiving any pain medication or medical treatment. A provider saw the patient on 11/20/12 and noted that the referral to the hand surgeon had been denied by utilization review on 10/26/12 because the criteria for a fracture had not been "met." The provider documented that the patient's finger was still swollen, tender and weak, and that he had difficulty gripping a pen. He further noted that the patient stated that he wanted the function of his finger to be restored. The provider ordered Tylenol with Codeine for the pain and advised the patient to file a grievance. The provider saw the patient for follow-up on 1/25/13 and noted that he was still complaining of pain and swelling of his finger. The provider ordered another x-ray and noted that he would resubmit the referral if there was still a significant fracture. The x-ray was performed on 1/30/13 and revealed persistent swelling of the finger with anatomic alignment and no definite fracture identified. The radiologist suggested an MRI for further characterization. The provider notified the patient that his x-ray was unchanged and that no follow-up was required. The provider saw the patient again on 4/11/13 for finger pain. The provider noted that there was decreased range of motion of the patient's finger and submitted an urgent referral to the hand surgeon. The hand surgeon saw the patient on 4/19/13. He noted that the patient's finger was unstable, painful and stiff, with deviation at the first joint. He recommended surgical repair. A provider saw the patient for follow-up of this visit on 4/23/13. He ordered Tylenol with Codeine for pain and follow-up with the primary care physician in 1 to 14 days. He did not submit a request for the surgery. A provider did not see the patient again until 5/28/13, at which time he submitted a request for surgery. The patient had the surgery on 6/6/13.[132]

Assessment

The patient did not receive timely care for his finger problem. It was not clear from the medical record why utilization review had initially denied the referral to the hand

[131] The volar plate is a very thick ligament in the hand that prevents a finger from hyperextending. If a lot of force is applied to the ligament during hyperextension (such as when a finger is jammed), the Volar Plate can rupture at the point where it is attached to the finger. This results in a small piece of bone from the finger being pulled off by the ligament as it is hyperextending. Volar plate fractures are usually treated with immobilization for a few days followed by range of motion exercises.

[132] Specialty Care Patient #9.

surgeon. Furthermore, there was a five-week delay from when the surgeon recommended surgery to when the provider submitted a request.

- The patient is a 37-year-old man with a history of paranoid schizophrenia who has been on a Keyhea order due to grave disability for many years. In October 2010, he was found to have a neck mass and difficulty swallowing. He had an ultrasound performed on 12/2/10 which revealed a "complex structure" near the thyroid gland. On 3/30/11, he had a biopsy which revealed some atypical cells and raised the possibility of Hodgkin's lymphoma. (The original biopsy report was not present in the eUHR.) The patient saw an ENT surgeon on 4/14/11 who recommended an evaluation by a vascular surgeon to rule out a carotid body tumor. On 6/13/11, the primary care provider referred the patient to the vascular surgeon on an urgent basis. (We were unable to determine the reason for the two-month delay between the recommendation and the referral.) The patient did not see the vascular surgeon until 7/29/11. The vascular surgeon recommended a CT angiogram to further evaluate the mass and follow-up after the scan. On 9/28/11, the patient refused to have the angiogram. Providers saw him that day and on 11/7/11 and counseled him on the potential consequences of his refusal, but he continued to refuse the study. A provider did not see the patient again until 1/18/12, at which time he referred the patient back to the vascular surgeon on an urgent basis for consideration for alternative modes of treatment. On 2/1/12, there is a refusal form noting that the patient refused his appointment with the vascular surgeon on 1/31/12. However, the patient wrote on the form that he did not refuse his appointment, that he did not know anything about the appointment and that he wanted to be rescheduled. On 2/2/12, he was admitted to SVPP. He was discharged and returned to SVSP on 1/10/13. On 1/24/13, the primary care provider evaluated the patient and referred the patient on an urgent basis to ENT for evaluation of his neck mass. On 1/30/13, the patient saw an ENT surgeon via telemedicine. The surgeon noted that the patient was having difficulty swallowing solid food for the last year with regurgitation. The surgeon noted that he would order a CT scan and a barium esophagram and then see the patient for follow-up, at which time he would set him up for removal of the mass. A provider reviewed the recommendations on 2/1/13 but did not order the recommended tests. He referred the patient to the primary care provider in one week so he could order the tests. The CT scan was not ordered until 2/15/13. The provider ordered it on an urgent basis and noted that he would consider the recommendation for the esophagram once the CT scan was completed. The CT scan was done on 3/4/13 and revealed an enlarged lymph node of uncertain etiology or significance. A provider reviewed the results of the CT scan on 3/7/13 and noted that the patient would need a biopsy of the neck mass. He referred the patient to the primary care provider in two weeks but did not order the specialty consultation. The primary care provider saw the patient on 3/18/13 and referred him on an urgent basis to the ENT surgeon for a fine needle biopsy. The biopsy was performed on 3/28/13. The pathologist noted that the pathologic findings were suspicious for

Hodgkin's lymphoma. He further noted that the diagnosis was difficult to reliably make on fine needle aspiration and usually required excision of the lymph node with the material submitted for special studies. He added that the patient's fine needle aspirate from two years before had showed a similar appearance and a recommendation for an excisional biopsy. On 4/4/13, a provider submitted an urgent request for an excisional biopsy to rule out Hodgkin's lymphoma. The biopsy was performed on 4/25/13. The pathologist noted that due to some abnormal findings, he was submitting the specimen to Stanford University to further evaluate for the presence of lymphoma. A provider saw the patient for follow-up on 5/6/13 and noted that the pathology report was not available. The provider saw the patient on 5/13/13 and noted that the pathology report revealed the presence of lymphoma. He further noted that he would order an urgent PET scan to assist in staging of the lymphoma and to rule out any other origins. He further noted that he would refer the patient on an urgent basis to Radiation Oncology for further evaluation consultation in regards to treatment. The PET scan was performed on 6/4/13. On 6/10/13, the provider referred the patient to an ENT surgeon at a tertiary care center. On the referral, he noted that the PET scan was negative. (The results of the PET scan were not in the medical record as of 6/14/13.) A provider saw the patient on 6/18/13 and noted that referrals for ENT and oncology were pending and that the results of the PET scan were not available. The provider noted that he would ask the nurses to obtain the PET scan report and discuss with the scheduler the need to expedite an urgent oncology appointment. On 6/25/13, the patient saw an ENT surgeon who recommended surgery to remove the mass. A provider saw the patient for follow-up of the ENT visit on 6/26/13 and referred the patient for the procedure and also noted that the results of the PET scan still need to be obtained.[133]

Assessment

There were multiple delays in the evaluation of the patient's neck mass while he was at SVSP. While two of these delays were due to the patient's refusal, the vast majority were related to provider issues. The original biopsy was not appropriately followed up on and then there were multiple delays when the patient returned from SVPP. Furthermore, the providers at SVSP failed to follow-up and ensure that the patient received the care that he needed when he was at SVPP.

[133] Specialty Care Patient #10.

Correctional Treatment Center Care (CTC)

Methodology: We toured the CTC, interviewed CTC health care and custody staff and reviewed CTC tracking logs and patient health records.

Findings: There are 12 medical and 10 mental health beds on the CTC unit at SVSP. We noted that the unit was clean and that patients on this unit had clean bedding. Although there was clutter in the halls, all patient areas, including showers, were orderly and sanitized. We also noted excellent access of clinical staff to patients. There were sufficient officers on the unit and clinical staff appeared to work well with custody staff assigned to the unit. We commend the Warden for custody efforts on this unit.

The OIG Cycle 3 report does not address care on the CTC unit. However, in February 2011, the California Department of Public Health (CDPH) inspected the CTC at SVSP and issued a statement of deficiencies related to their audit of the CTC. There were more than 40 identified deficiencies. CDPH required a corrective action plan, which SVSP provided. Once a corrective action plan was provided, the case was considered closed and, based on what we were told, there was no re-inspection of the unit.

The CDPH audit found significant sanitation issues which, based on our observation, appeared to have been corrected. Inmate rooms were clean, and inmates all had proper bedding and dressings, which apparently was not the case in 2011. Although the halls were cluttered with equipment, we found sanitary conditions generally good.

While we did not inspect all areas which had been inspected by CDPH, we did note some problems which appear not to have been corrected. CDPH found that there was a failure to adequately ensure that nursing care plans were developed and implemented consistent with the medical care plan of the patient and that there was failure of a multidisciplinary team to develop a treatment plan within 72 hours of admission. We found the same problem, indicating that this problem has not been corrected. Nursing care plans were often unrelated to the needs of the patient. Nurses made up ad hoc care plans, resulting in patients not always receiving consistent care for their needs. Physician orders for care were not synchronized with care needs or with nursing treatment plans, which resulted in disjointed care.

CDPH also cited SVSP for failing to document the types of solutions used for cleaning decubiti,[134] the types of dressings used, and descriptions of when the wound was cleaned and what the measurements of the wound were. We found nurse treatment plans for decubiti care so non-specific that each nurse would develop his or her own method of cleaning and dressing the wound. This is not good practice. Care plans need to be developed in conjunction with physicians, and orders need to be clear so that care is standardized and consistent.

[134] Pressure ulcers.

CDPH also found that there was failure to complete pain assessments for persons on morphine. While we found physician development of a pain treatment plan to be more of a problem, in general, this institution had problems with management of pain and documentation of pain therapy.

CDPH also found SVSP deficient for failure to maintain patient health related information readily available at all times. Specifically, consultation reports and laboratory reports were removed to make the charts thinner and were unavailable in the record. We observed the same problem on our tour and describe one incident in the patient section below. In regards to medical record keeping, we also noted two other significant problems. One was legibility of the physician records. The hand script of physicians was not legible and, in some cases, we had to ask the practitioner to interpret notes. Dictated notes are an option at this facility and would be a significant improvement in patient safety. Also, no patients on this unit had a problem list in their paper medical record, which was the record of use on this unit. It was not possible to determine all of a patient's problems by reading the medical record. This was exacerbated by the fact that physicians' assessments and treatment plans do not include all of the patient's problems. The physician will write a note that only addresses the problems addressed by the physician that day; not all of the patient's problems are listed. A consequence of this is that patients may be put on medication for a specific problem, but when that problem is not tracked, the patient may remain on the medication; it is almost impossible from the record to determine why the patient is on the medication. We noted this problem for several patients. This lack of internal tracking, by not noting all problems in the assessment, results in episodic care. When all problems are listed in the assessment with all outstanding treatments and plans, there is less likelihood of something getting missed or lost. We note examples of missed care resulting from this in the patient summaries below.

We also noted that the CTC unit was a combined unit, housing both mental health and medical patients. We noted problems when a patient admitted for a mental health condition also had medical problems. The patient was not thoroughly followed for his medical conditions. This is described in one of the chart reviews below.

Lastly, the CTC policies need significant revisions as previously explained in the policy section.

The following patient examples illustrate the problems listed above.

One patient[135] had a problem list in the eUHR listing severe chronic obstructive lung disease (COPD), dyslipidemia, hemorrhoids, low back pain and rheumatoid arthritis. There was no problem list in the paper medical record and it took some effort to determine that the patient actually also had disseminated cocci, although we could not determine where the cocci had disseminated to. Especially when dealing with patients with complex medical problems,

[135] CTC Patient #1.

checklists and lists in general are an important means of ensuring safety.[136] The SOAP format is a way to organize the medical record and, when the assessment section utilizes a list of all medical conditions, it is less likely that important interventions will get lost. This is a means to ensure patient safety. For this patient, the lack of a clear list of problems made it hard to track care for the patient, which was magnified by physician note illegibility and failure to document all problems and therapy plans in their daily notes.

This patient's current 23 medications included Tylenol, albuterol inhaler, amitriptyline, atorvastatin, bisacodyl, calcium carbonate, chlorhexidine mouthwash at bedtime, docusate, Lovenox, fluconazole, folate, hydroxychloroquine, leflunomide, levalbuterol, levetiracetam, magnesium hydroxide, megestrol, methocarbamol, Mirtazapine, morphine, sucralfate, tolnaftate and zinc oxide.

From March to June 2013, the patient was seen by five different physicians. Because the progress notes did not include an assessment of each problem with a therapeutic plan for each problem, it was not immediately clear why the patient was using each of these 23 medications. It was unclear to us as we did our review why each of these medications was being used, and it would probably have been unclear to any one of the five physicians assuming care for this patient. Discovering the need for each of the 23 medications was a daunting task in our review of this patient. Some problems were listed some days, and other problems listed other days. Some days no problems were listed. It was therefore not possible from the progress notes to follow the course of care for the patient. This inevitably causes patient safety concerns and is substandard care.

The result of this lack of detail was that certain problems and medications were not monitored. The paper chart did not have a problem list and the patient's chronic obstructive lung disease was not being included in physician progress notes, so it was not clear initially why the patient was taking albuterol. I asked the physician why the patient was on albuterol, and the physician indicated that the patient had chronic obstructive lung disease, but this condition was not documented in the paper medical record and there was no monitoring for this condition except for occasional pulse oximeter. Also, the patient was on megestrol, which is a hormonal appetite stimulant, but there was no documentation available in the record to indicate why the patient was taking the medication and what the therapy plan was for this medication. The reason why the patient was on each of the other medications was not readily discernible from inspection of the record. The patient was on hydroxychloroquine and the physician on the unit who actually renewed the medication six weeks earlier was unaware that the patient was on the medication. There was no monitoring of this medication, which typically includes ophthalmology examinations every three months, evaluation of muscle strength, and periodic liver function tests and complete blood counts. There were no ophthalmology examinations in the record. The last laboratory results for this patient in the eUHR were in July 2012, about a year before

[136] The Checklist Manifesto-How to Get Things Right, Atul Gawande. Metropolitan Books 2009.

our visit. Except for a cocci titer and thyroid test, there were no laboratory reports in the paper record. The lack of tracking of problems and medications is a patient safety issue and placed this patient at risk.

The patient was bedridden but it was not immediately clear why he was bedridden. We eventually discovered that, apparently, the patient was bedridden because of his severe rheumatoid arthritis, which completely incapacitated him. It was not easy to discern the reasons for his incapacitation from the record. The most detailed summary of the rheumatoid arthritis in the chart was from a psychiatrist who documented that the patient had severe rheumatoid arthritis with upper and lower extremity deformities, severe flexion contractions of the upper extremities and hips, C1 and C2 laxity, and multilevel cervical spondylosis. The neurosurgeon had recommended spinal decompression of C1-2. The psychiatrist also described decubiti and pulmonary cocci. This level of detail was not present in any of the medical physician notes. Hand written physician notes in the chart were difficult to read and did not describe what the patient's condition was in sufficient detail.

With respect to the care plan, we spoke with the nurse for this patient and reviewed the care plan. The tasks that the nurses and aides perform daily for this patient exceed that which is documented in the nursing care plan. The nursing care plan is not synchronized with physician orders and some treatments given by nurses, particularly related to skin care, are not all ordered. Because the written care plan does not reflect what needs to be done for this patient, some care items are not performed when the usual nurse is not working. For example, the patient had three decubiti. One was nearly healed, and two others on the buttock needed attention. The care plan did not specify what the decubiti care consisted of. So, each nurse on each shift decided how to care for the decubiti. For example, the nurse we spoke with washed the decubiti each morning with a medicated wipe followed by antibiotic ointment and duoderm[137] cut to cover the wound. Other skin surrounding the area was covered with zinc oxide. This exact sequence was not ordered care but was the typical procedure of this nurse. When this nurse was not working, other nurses performed this care in their own particular style. For the two previous days, the wounds were not attended to in this manner and the decubiti had worsened, according to the nurse. The treatment plan should be discussed with the physician during rounds, standardized, described in a treatment plan, performed consistently and documented once in the same location in the record.

Currently, care plans are not consistently developed as ordered; are specific to specific nurses; are documented in multiple locations in the medical record (kardex, interdisciplinary care plan sheets); and are not specific to the needs of the patient or reflective of actual care provided to patients. Since this has been identified as a problem at multiple licensed units, it would be worthwhile to address this on a system-wide basis.

[137] A medicated bandage.

Another patient[138] is an 89-year-old man who had a CTC admission record listing Parkinson's disease, cold agglutinin disease and chronic atrial fibrillation as medical problems. Sorting through the paper medical record, it was possible to find other problems listed on various notes which included squamous cell carcinoma of the face post radiation therapy, hypothyroidism and abdominal aortic aneurysm (mentioned once over three months). These problems are not listed all together on any physician notes. Plans for each of these problems are not clear and are not included in the three times a week notes by the physician. As a result, it is difficult to follow care of the patient. Not unsurprisingly, this patient was lost to follow-up for his squamous cell carcinoma.

As a practical matter, a history of the squamous cell carcinoma is best found in a consultant's note because progress notes are difficult to read and do not appear to adequately summarize the history of each problem. According to a consultant note on 1/15/13, the patient had longstanding multiple excisions for basal and squamous cell carcinoma of the face. The consultant wrote that an initial evaluation occurred in February 2011. At that time, the patient had an excision of multiple lesions and squamous cell carcinoma was present in resected margins. When cancer is identified in resected margins, this calls for additional resection until the margins are free of cancer cells. The consultant documented that no additional intervention occurred at that time until the patient re-presented in December 2011 (nine months later), at which time a radical excision of part of his right ear was performed. The margins of this excision revealed squamous cell carcinoma. The patient was scheduled for re-excision, but the consultant was not certain whether this occurred. There is no evidence in the record that this occurred. The physician on the unit told me that the margins were clear but there were no pathology reports in the record to verify this.

One year later, the patient re-presented with an ulcerated lesion on his right ear but the patient declined surgery because of his "overall frail state." The patient was referred for radiation oncology for radiation therapy. The radiation therapy was completed on 3/13/13 and the patient was supposed to follow-up in one month. A provider did submit a request for service for radiation therapy on 3/13/13, but there is no evidence that this appointment had occurred as of our visit in June 2013. In addition, a provider referred the patient to an oncologist on 3/20/13, noting that the appointment needed to occur as soon as possible. The oncologist did not see the patient until 4/12/13. At that appointment, the oncologist had no information about the squamous cell carcinoma and asked for a follow-up in four weeks with records. He did note the problem with cold agglutinins and recommended blood tests and follow-up with the results of the tests. The patient returned to the oncologist on 5/24/13, but the records of the squamous cell carcinoma were not provided and the oncologist did not evaluate for that condition. As a result, the patient was not evaluated for the problem for which he was referred. The oncologist noted the laboratory results and diagnosed cold antibody hemolytic

[138] CTC Patient #2.

anemia with stable hemoglobin and recommended a follow-up in three months. The patient has yet to have follow-up of his squamous cell cancer which was initially an ASAP request in March.

This is extremely disjointed care in which the patient is subject to missed appointments and delayed treatment for a potentially life threatening condition. In looking through the eUHR, a pathology report from 12/24/11 was present showing squamous cell carcinoma involving margins. There was no pathology report from 2/2011 and there was no pathology report from 2012. This patient's skin cancer appears to have been neglected and follow-up is not occurring. We note that CDPH cited the CTC for absence of medical record documents that had been removed during the chart thinning process. This needs to be re-evaluated by management in a root cause process evaluation.

Regarding anticoagulation for the patient's atrial fibrillation, the patient's last INR was subtherapeutic at 1.7 on 4/24/13, almost six weeks prior to our visit. Based on INRs in the paper record, he had not been therapeutic since 12/19/12. The CPHCS care guideline for anticoagulation recommends adjusting the INR between 2-3 for a patient with this condition. This problem is not being monitored in accordance with CPHCS guidelines. The physician explained this by stating that, several months back, the patient experienced hematuria and because of his risk (abdominal aortic aneurysm and Parkinsonism with risk of falls), he decided to be less aggressive with anticoagulation. However, a therapeutic goal has not been established, and expert guidance was not sought in determining an alternate therapeutic goal for this patient. The patient remains on 2 mg of warfarin a day and is not consistently monitored for INR and has no documented target INR. What is not clear is whether giving 2 mg of warfarin a day still places the patient at risk for bleeding given his abdominal aortic aneurysm and risk of falls. This patient would benefit from seeing a hematologist and getting an established treatment plan.

The patient also had Parkinsonism. We could not find documentation in the paper record of monitoring of symptoms of Parkinsonism or of mental status evaluations. This is not standard of care for management of Parkinsonism. This patient has not seen a neurologist.

Another patient[139] is a 61-year-old man who was in an OHU at Valley State Prison (VSP) when he was transferred to a mental health bed at SVSP on 4/8/13. He was a mental health patient and was found by officers smearing feces and placing his urine in a cup under his bed. He was found fully clothed in the shower and at other times found soaked in urine. The patient seemed unaware of how this happened. He was on haloperidol and was diagnosed with psychotic disorder and a cognitive disorder with borderline IQ. Because he was difficult to control in the OHU, he was transferred on 4/8/13 to an SVSP Mental Health Crisis Bed for management. On the unit, the patient continued with fecal and urinary incontinence. The primary care physician

[139] CTC Patient #3.

ordered an MRI on 4/10/13 for grave disability with urinary incontinence, gait disturbance and possible dementia. The MRI was unable to be done because the patient had buckshot in his shoulder. A CT of the brain was requested urgently on 4/25/13 and approved on 4/26/13. There is no evidence of a CT report in the eUHR or in the paper record report section, but a mental health note documents that the test was normal. This confirms the citation by the CDPH that medical record documents are not found in the chart. An urgent sonogram of the kidney was ordered on 4/9/13 and was a limited study showing an enlarged prostate.

On 5/8/13, a request was made to the DSH for placement but was refused because the patient's symptoms indicate a medical problem. We note that although the patient had been on the unit almost two months, a thorough neurological assessment had yet to be performed by the primary care physician. Moreover, there was a paucity of physical examinations. A neurology consultation was requested on 5/15/13. The patient had not been examined neurologically by an SVSP provider, yet he was referred to a neurologist. This is not appropriate care.

The last note by medical was on 5/30/13 and documented that the patient was awaiting return to the OHU at VSP. Transferring him back to VSP without a diagnosis is medically inappropriate and unsafe. Even though the patient is a mental health patient, his treatment plan should include collaborative clinical follow-up by medical staff. The patient may have a significant neurological problem identifiable by physical examination, and it is standard of care for him to have a physical examination appropriate for his condition.

Another patient[140] was also on the CTC for a mental health condition. He had a colostomy apparently from a prior toxic megacolon[141] but documentation of this was not found in the paper record. The patient was in and out of the CTC in a mental health crisis bed due to his inability to manage in general population regarding his colostomy care. On 1/28/13, a psychiatrist documented that the patient was on three psychiatric medications, Remeron, lithium carbonate and Risperdal. On 2/20/13, psychiatric staff transferred the patient to a medical bed on the CTC pending transfer to an OHU for medical care.

The initial medical note on 2/25/13 only listed colostomy care as a medical problem, and it looked like that was the only reason the patient was on the medical unit. The patient's remaining problems were mental health. However, on 3/11/13, a medical provider note documented hepatitis C infection, eczema, a skin lesion, and hypertension. His medication was not documented. On 3/13/13, a provider documented normal electrolytes but did not document the date these were drawn.

[140] CTC Patient #4.

[141] Toxic megacolon is a life-threatening complication of other intestinal conditions. It causes widening (dilation) of the large intestine within 1 to a few days.

On 3/15/13, the patient was noted to be vomiting and had a pulse of 108/minute. Our review revealed that he was intermittently refusing vital signs and had refused a lithium level. A physician did not evaluate the vomiting. This is not standard of care, as the patient had abnormal vital signs and was on lithium, which can cause vomiting as a side effect.

On 3/16/13, the patient felt nauseated and had a pulse of 112/minute. The nurse called the primary care provider, who advised the nurse to push fluids. On the same day, a physician gave a telephone order for promethazine, as needed for vomiting. A physician did not examine the patient and no follow-up was ordered or occurred. Later that day, a different physician gave a telephone order to hold the lithium due to nausea and vomiting and the nurse documented that the patient would be reassessed the following day. This reassessment did not occur. The patient had an elevated pulse. Prescribing an anti-emetic without evaluation is not standard of care.

On 3/17/13 and 3/18/13, the patient had no vomiting. On 3/20/13, a physician (presumably a psychiatrist) renewed the lithium carbonate but the patient had yet to be reassessed. On 3/21/13, a physician saw the patient and documented no complaints and no vomiting. The physician did not document the phone orders for the anti-emetic. The physician noted normal laboratory findings but these labs had been reported 3/13/13, which was before the patient experienced vomiting and should not have been used to arrive at a clinical conclusion for his recent vomiting.

On 3/24/13, the patient was vomiting again and a physician gave a phone order for Gatorade and promethazine. There was no physical examination on this date. On 3/25/13, the patient had nausea and vomiting and was noted to have laboratory findings consistent with renal injury from dehydration. His sodium level was 123 mEq/L which is an extremely low and dangerous level. The patient was admitted to a hospital. This patient needed to have been evaluated in person on the day he first started vomiting, which was 3/15/13. Laboratory tests needed to be drawn then and repeated as frequently as necessary. Instead, this patient was not evaluated timely, did not have laboratory tests drawn timely, and was placed in danger by virtue of substandard care.

At the hospital, the patient was described as cachectic. He had a fecal impaction in the distal sigmoid colon with a dilated colon and small bowel. He was severely dehydrated. He had diagnoses of dehydration, fecal impaction and hyponatremia (low sodium). He was rehydrated and discharged on 3/27/13. The hospital suggested that the hyponatremia was secondary to his psychotropic medication and excessive fluid intake.

The nursing care plan at the time of our visit for this patient included a pre-printed form for fluid and electrolyte imbalance related to chronic renal failure and listed interventions such as assessing blood pressure, edema, monitoring weight and vital signs. These interventions are not relevant for this patient as his problem is that because of his mental illness he was drinking excessive quantities of water and developed hyponatremia. The nursing care plan needed to

address this specific concern. Nothing in the current care plan addressed fluid intake or bowel hygiene. Since the patient had a colostomy, this should not have been difficult to do. This confirms that the CDPH deficiency citation has not yet been corrected.

The patient was described as cachectic at the hospital. Upon return to the CTC, the physician ordered fluid restriction of 1.5 liters a day with daily blood tests until the serum sodium was > 130 mEq/L. There were no instructions to measure input and output or to check bowel hygiene. On 4/2/13, the fluid restriction was discontinued but no monitoring was established to check on whether he was drinking too much fluid. His weight was not being monitored. This is episodic care. The patient's hyponatremia was related to a mental health behavior which would not be corrected when the serum sodium returned to normal. The treatment plan needed to have been developed with mental health and needed to include monitoring of his fluid intake and electrolytes until the behavior was successfully addressed.

On 4/24/13, the physician ordered staff to "periodically monitor" the patient for fluid intake. This non-specific order did not result in an appropriate care plan. Blood tests have only been ordered monthly. The patient's weight has not been taken since his return from the hospital. Though the patient pulls his colostomy bag out as part of his mental health condition, monitoring for this is not part of the treatment plan.

Another patient[142] has been on the CTC for about 22 months, yet there is no problem list on the chart. His CTC admission history lists diabetes, ulcerative colitis, hypertension, prior stroke, urinary incontinence and decubiti as medical problems. He also has ankylosing spondylitis,[143] which is not listed on the CTC admission history. The patient is bedridden and requires total nursing care. He is on 26 medications, including methotrexate, which can cause very serious, life-threatening side effects, for his ankylosing spondylitis. There are six pre-printed care plans for this patient. These address chronic pain, decubiti care, diabetes, falls and activity. None of these, except for the diabetes care plan, specifically addresses nursing tasks that the nurse performs for the patient on a daily basis. Therefore, the care plan does not offer a standardized list of assignments for nurses for this patient.

Patients with ankylosing spondylitis generally receive pain assessments, functional assessments and assessments of the degree of inflammation. Physical therapy is recommended. This patient was not receiving care consistent with the above.

On 9/7/12, a rheumatologist saw the patient via telemedicine for his ankylosing spondylitis and the rheumatologist recommended continuing methotrexate six tablets once a week with close follow-up of liver function tests. He recommended follow-up in six weeks. There is no evidence of this follow-up with the rheumatologist. The most recent liver function test was 5/16/13 and was normal. The patient received some physical therapy, but there has been no documented

[142] CTC Patient #5.
[143] Ankylosing spondylitis is an inflammatory disease that can cause some of the vertebrae in the spine to fuse together.

physical therapy since July 2012, almost a year ago. Progress notes for the prior three months did not contain any history assessing the patient's pain, functional status or degree of inflammation. The assessments for ankylosing spondylitis mostly document the disease and indicate that the patient is tolerating medication. The last note on 6/3/13 assesses the ankylosing spondylitis as "doing well on methotrexate, folate and Asacol (a medication used to treat inflammation) and continue with current plan." The last sedimentation rate was from 4/2/13 and was elevated, indicating continued inflammation and possibly poorly controlled disease. We spoke with the patient. He has not seen a rheumatologist in a long time, receives no physical therapy, and is not routinely asked about functional status or assessed for pain by the physician.

On 3/4/13, the patient was described as having anemia and awaiting a colonoscopy. On 4/3/13, he had blood tests indicative of iron deficiency anemia. He had a colonoscopy done 4/18/13, but the report was not yet in the medical record and was not available in the eUHR. On 5/27/13, a physician note documented that he informed the patient of the colonoscopy results, but the physician did not document the results and these results were not in the paper CTC record or in the eUHR. The patient's diabetes and hypertension were in good control.

Mortality Review

Methodology: We reviewed CCHCS Death Review Summaries for 19 deaths that occurred in calendar year 2012. In addition, we reviewed three death records as well as the respective CCHCS Death Review Summaries.

Findings: There were 19 deaths at SVSP in calendar year 2012. Six were suicides, 3 appeared to be homicides, 4 were due to end-stage liver disease and 6 were due to other medical conditions. We also note that there was one patient reviewed above in the hospital care section that developed esophageal, stomach, and rectal cancer while at SVSP and died at another facility as a result of that illness. As with most of the other sites, SVSP does not perform its own comprehensive mortality review; instead, these are done by CCHCS Central Office staff.

The mortality reviews include one case of inappropriate prescription of narcotics and one case of narcotic overdose for a patient not on prescription narcotics. As we noted in other sections of this report, there are problems with prescription of narcotic medications at SVSP. There were 283 prescriptions for methadone and morphine alone. This does not include other narcotic medication such as codeine. There were numerous episodes when patients were identified as diverting drugs to recreational use. As noted above, the CTF facility had a serious issue with drug diversion by staff, and management indicated that they believed the problem extended to SVSP as well. One nurse is under disciplinary proceedings in part for diversion. We reviewed one record of an inmate who died of drug intoxication. This inmate was not prescribed the drug from which he overdosed. The improper use of narcotic medication has three unintended risks. First, in those for whom inadequate evaluations and indications exist for prescription narcotics,

physicians are placing those inmates at risk for dependence, addiction, and possible overdose. Second, the indiscriminate use of narcotics increases the volume of drug which can potentially be diverted for improper use. This places other inmates at risk. Third, indiscriminate use of narcotics increases staff labor because of the meticulous tracking that is required by pharmacy regulations. As well, when large quantities of narcotics circulate in a system, there is increased temptation for diversion on the part of employees. Evidence of these unintended consequences coexists at SVSP or CTF. For all these reasons, physicians have a serious responsibility and obligation to adhere to the California Guideline for Prescribing Narcotic Medication and ensure that appropriate pain relief is provided to patients.

In general, the mortality reviews were of reasonable quality but failed to identify all problems. Some missed problems were significant. Evidence of poor care or systemic issues impacting care were not always identified. Failure to identify these issues results in inadequate peer review and/or quality improvement activities.

The first death[144] we reviewed occurred on 7/23/12. This patient had a history of depression, high blood lipids, reflux disease and chronic degenerative joint disease resulting in chronic pain. The only medical physician note in the eUHR is from 10/3/11, when the patient was seen for chronic low back pain. There was inadequate history and physical examination for this patient's low back pain, yet the patient was prescribed medication for this condition. The physician also noted that the prior TSH was 5.5 mIU/L, indicating hypothyroidism. The physician noted that a recent TSH was normal, but we could not find the result of this test in the medical record. The physician's assessment was that the patient had incipient autoimmune hypothyroidism causing increased cholesterol. He documented no treatment at that time but noted that the TSH should be re-checked in six months. The physician also noted that the patient said that Zantac was not working for his heartburn and he wanted to resume Prilosec. The physician ordered Prilosec but discussed "addiction to PPI per Medscape" with the patient. There is no known addiction to Prilosec. A 90-day follow-up was ordered. This did not occur. The patient was not seen again by a medical physician at SVSP, so his several medical conditions were never followed up. This patient was not seen for over nine months. This is not good practice.

Laboratory tests from 2/18/11 indicated that the patient LDL cholesterol was slightly elevated (133 mg/dL). There was a previous LDL cholesterol of 163 mg/dL present in the eUHR from 5/29/08. This test was never repeated after 2/18/11, and the patient was not advised regarding diet. This was not good care.

On 7/23/12 at 11:28 a.m., the patient was found unresponsive. The Coroner went to the prison to inspect the decedent. The Coroner noted that the cellmate had told an investigator that the patient may have been crushing pills and snorting them the night before he was found.

[144] Mortality Review Patient #1.

There was a laboratory toxicology report reported to the Monterey County Coroner stating that the patient had morphine 0.30 mg/L in his blood at the time of his death even though the patient was not receiving morphine. The effective level for morphine was given as 0.01-0.12 mg/L and potentially toxic levels were given as 0.15-0.5 mg/L. So this patient had a potentially toxic level of morphine in his blood at the time of death. This confirmed the death as morphine intoxication. The Coroner in the autopsy documented that the morphine level was very high for a non-tolerant subject.[145] The patient also had Effexor (an anti-depressant) in his blood which was not prescribed for him. Two prescribed medications, Mirtazapine and chlorpromazine, were not found in the toxicology study. This should result in a root cause analysis of two items. One is administration of medications to ensure that procedures are in place to prevent diversion. The second is a systematic root cause analysis of the prescription of narcotics based on established indications.

A second death[146] involved a patient who died of a massive mycotic aneurysm[147] of the brain. The patient had hepatitis C, prior endocarditis (infection of a heart valve), a prosthetic heart valve (done because of the endocarditis), and rheumatoid arthritis. Although the rheumatoid arthritis was listed in the problem list, there is no evidence that the patient actually had this disease. However, because physicians never performed a history or physical examination for this disease, there is little evidence to state the he did or did not have the disease.

This patient had a prosthetic mitral heart valve. However, from the eUHR it was not possible to determine what type of valve this was. This was important because anticoagulation is typically recommended for prosthetic heart valves, but the degree of anticoagulation varies by the type of valve. Also, follow-up and valve replacement schedules also differ based on the type of valve. In this patient's case, his valve was described as a pig valve, mechanical valve, and bioprosthetic valve in various parts of the record. Anticoagulation recommendations are different for each of these valve types. But, more importantly, primary care physicians at SVSP never discussed anticoagulation in their progress notes and from early 2011 until December 2011, the patient was not on anticoagulation at all. Not prescribing anticoagulation for a person with a heart valve is substandard care.

A physician saw the patient on 8/3/11 for follow-up of his hepatitis C and rheumatoid arthritis. There was no mention of the prosthetic heart valve in the history or assessment. The history also failed to include the reason why one of the patient's medications (furosemide, a diuretic) had been ordered. The only history of pain was that the patient complained of joint pain at night. There was no documentation related to pain or arthritis in the physical examination (i.e., joint deformity, swelling or tenderness). In the assessment, the physician documented that the

[145] Tolerance is the physiologic process by which the body adjusts to certain levels of a narcotic resulting in the ability to tolerate higher doses.
[146] Mortality Review Patient #2.
[147] A mycotic aneurysm is an abnormal arterial dilation caused by bacterial emboli, typically arising from bacterial infection of a heart valve.

patient had rheumatoid arthritis and that he would refill the morphine. This is not typical for treatment of rheumatoid arthritis and is a very poor history and physical examination related to a prescription for morphine. The only problems listed in the assessment were rheumatoid arthritis and hepatitis C. In the plan, the patient was not on anticoagulation despite a mechanical mitral valve. The physician prescribed morphine for six months with a five-month follow-up. This is substandard care.

The patient was next seen by a physician on 10/26/11. This was based on a 7362 health request placed on 10/18/11. The physician noted that the patient had prior surgery for endocarditis but remarkably did not note that the patient had a mechanical mitral valve. The physician wrote that the patient was "requesting for heart surgery." This was not coherent. The physician noted echocardiogram results but did not include the date. The echocardiogram in the eUHR in backfile was from 3/10/11 and appears to be the most recent echocardiogram relative to the date of this visit. This study documented a mechanical mitral valve. The echocardiogram was signed as reviewed on 10/27/11. It appears that the physician either did not review the study carefully, or did not believe a mechanical mitral valve required follow-up, or did not know the clinical requirements of anticoagulation of prosthetic valves. The assessment was chest wall pain and cardiomegaly. Because the patient had a history of cardiomegaly, the patient was referred to a cardiologist. The rheumatoid arthritis was not addressed by history or physical examination. Pain was not addressed in the history or physical examination except to document chest wall pain. The reason for the patient being on furosemide was not clarified in the history or assessment. The anticoagulation issue was again not discussed. If no anticoagulation was recommended because the valve was bioprosthetic and he did not have risk factors, this needed to be documented somewhere in the record.

On 12/3/11, the patient experienced loss of sensation in his toes with extreme pain in his leg. A nurse evaluated the patient. The nurse noted that the patient's toes and foot were cold to touch and there were bilateral diminished pulses in his feet. The nurse sent the patient to the TTA. The TTA nurse contacted the on-call physician via telephone. The nurse reported that the patient's left leg was cold and that his right leg had normal temperature. The nurse was concerned about a DVT; the physician was not in agreement. The physician recommended holding the patient in the TTA and rechecking the leg temperature in two hours. Later that day, at about 5 p.m., a physician came into the TTA and evaluated the patient and the patient was sent to a hospital. The physician did not document a note. The fact that the physician evaluated the patient is documented on the Emergency Care Flow Sheet. Every patient care encounter needs to include a documented note in the medical record.

At the hospital, the patient was diagnosed with an embolism to his left leg. Since this required specialized surgery, the patient was transferred to Stanford University Hospital. The patient underwent removal of clots from two arteries and a wide debridement of infected tissues of the leg. This left the patient with a large wound. While hospitalized, the patient was discovered to have endocarditis (infection of the heart valve) of the mitral valve and possibly the aortic

valve as well. This is a life-threatening condition. An unusual organism, Rhizobium radiobacter, was cultured from the arterial thrombus removed during surgery. Blood cultures were negative. This organism is a soil organism and is extremely uncommon as a pathogen, but has been recognized in the literature in one patient with a prosthetic valve. Typically, the organism is seen in immunocompromised hosts who have indwelling catheters. The organism is typically susceptible to two antibiotics, Zosyn and ciprofloxacin. A physician note at Stanford documented that the organism was likely due to injection drug use. We note that this patient had been on a prescription for morphine but had no reasonable established indication for narcotic medication. During hospitalization, the patient required transfusion and was discharged with hemoglobin of 9.8 g/dL (normal range 14.0-17.5 g/dL). A cardiothoracic consultant said that the patient was not an operative candidate and the patient declined any surgical procedure. While at the hospital, the patient was anticoagulated. The patient was discharged on OxyContin, acetaminophen, warfarin and Zosyn. His furosemide and potassium were stopped in the hospital. Follow-up cardiology and echocardiogram were recommended. Recommendations were to continue the antibiotics and not to stop antibiotics unless the patient was seen in follow-up at Stanford. While at Stanford, a pharmacy consultation was done and the recommendation was to anticoagulate the patient with warfarin to an INR of 2.5-3.5. The Stanford echocardiogram confirmed a bioprosthetic mitral valve.

The patient was discharged from Stanford on 12/12/11 and admitted to the CTC at SVSP. He required intravenous antibiotics for several weeks and attention to a large leg wound. Despite the fact that Stanford physicians had stopped the furosemide, it was continued at the CTC. However, no indication was established for this medication. On the CTC, the patient began refusing antibiotics which were critical for his survival. Physicians spoke with him about this and a psychiatrist was consulted, but the patient continued to refuse. On 12/16/11, the physician discharged the patient to general population.

Upon discharge, the CTC physician started oral Bactrim, which is ineffective for endocarditis. Typically, endocarditis must be treated with intravenous antibiotics in order to obtain an appropriate blood level of drug. Oral antibiotics do not provide the same blood levels, in part due to the fact that they are not immediately available in the blood but must pass through the digestive tract to be absorbed. It is not clear that the Rhizobium bacteria was sensitive to Bactrim, although in the literature this bacteria is described as sensitive to ciprofloxacin (a commonly available antibiotic). There was no consultation documented with the Stanford physician or with an Infectious Disease consultant about alternate therapy. The patient had also been on a wound VAC for drainage but refused this as well. He wanted to go back to the yard because he did not want to miss a visit from his father. Why the father could not visit on the CTC is unclear. While on the CTC, only one INR was obtained on 12/14/11, which was subtherapeutic at 1.4. The hemoglobin was slightly higher but still below normal (10.7 g/dL), but no follow-up laboratory tests were ordered. The prescription of Bactrim for endocarditis is substandard care. Sensitivities needed to be checked and an infectious disease physician needed to have been consulted. Sending the patient to general population was a serious error. This patient had a life-threatening illness and needed to be kept in the CTC whether he refused

medication or not. The CTC physician ordered follow-up with the primary care physician in 1 -7 days. A one-week follow-up for someone with inappropriately treated endocarditis was not responsible, as such patients require more frequent monitoring because their condition can deteriorate rapidly.

The patient did not have follow-up by a physician until 12/29/11, even though a seven-day follow-up was ordered. For a patient this ill, a two-week follow-up was inexcusable. The physician's history contained only some of the events that had occurred at Stanford. Remarkably, the physician's history reported, "He has been cared for since then after he left from Stanford." The physician did not note that the patient still had active endocarditis and was on inadequate treatment. The patient's rheumatoid arthritis was not discussed at all. The physician noted no murmurs on exam, even though the patient had active endocarditis and a heart valve. The physician noted that a recent INR was 4.5 and stopped the warfarin. He continued the morphine, even though physicians at Stanford conjectured that his endocarditis might have been caused by injecting drugs. An INR was ordered for two days. There was no discussion about why the patient was being anticoagulated, and it is not clear that the physician understood that the patient had a prosthetic valve. There was no discussion about re-starting antibiotics or discussion about why the patient stopped taking antibiotics. The wounds were examined. The INR laboratory result could not be found the eUHR. There was no history, physical examination, or assessment of the pain, yet morphine was continued. There was no follow-up of the anemia. The physician continued general population housing. This was substandard care.

On 1/4/12, a physician saw the patient and documented that no record was available. The history included documentation of prior valve replacement for endocarditis, but did not include that the patient had active endocarditis. The physician noted that the patient had thrombectomy and signed out from the CTC and was on Bactrim, but did not address that the patient refused intravenous antibiotics for endocarditis and did not note the organism infecting the patient's heart valve. Anticoagulation and rheumatoid arthritis were not addressed. The examination consisted of checking several boxes including "cardio" as within normal limits. There was a description of the wound. There was no mention of a prosthetic valve. The assessment only documented an acute ischemic leg. Active endocarditis, rheumatoid arthritis and prosthetic heart valve were not mentioned in the assessment. The patient was scheduled for a wound care appointment. The physician wrote to continue oral antibiotics, which was not standard of care for this condition. There was no attempt to get sensitivities of the Rhizobium bacteria. No mention was made of the warfarin. Laboratory tests were not reviewed and were not in the eUHR. It was documented on the note that the patient diverted narcotics, but there was no change in the morphine prescription. This was substandard care.

On 1/9/12, a urine specimen collected 12/29/12 was positive for methadone and morphine. The patient had no prescription for methadone, indicating that the patient was surreptitiously using methadone.

On 1/23/12, a physician saw the patient in primary care and documented that the patient had prior thrombectomy from an acute ischemic leg. Again, there was no mention that the patient had active endocarditis inadequately treated or that his anticoagulation had been discontinued. The rheumatoid arthritis was not addressed. The physician documented that the patient was seen at wound clinic and that the leg wound was healing. The physician's assessment only included ischemic leg and a prior history of endocarditis. Notably, in the assessment, the physician documented history of endocarditis but did not document that the patient had active endocarditis inadequately treated. There was no mention of a prosthetic valve. The heart examination box was checked normal, which was unusual given that the patient had endocarditis and a prosthetic mitral valve. Prior INR values were not in the eUHR. The anemia was not addressed. Narcotic diversion was noted on the record and the physician began a slow taper of the morphine. For reasons that were not stated, the physician started the patient on low dose aspirin of 81 mg. The physician noted in the plan that the patient had been on furosemide and potassium in the past, but did not comment on why the patient had been on these medications. There is a medication reconciliation form dated 12/3/11 in which these medications were discontinued, but there were no physician notes in the record explaining this action. However, these medications, based on medication administration records for December and January, appear to have been given until 1/3/12. It appears that they were not renewed. There is no documentation in the record as to why these medications were being used. Again, this is substandard care.

On 2/3/12, a physician saw the patient. A very brief history was taken. The physician noted that the patient was seen in relation to a nurse dressing change. The only history documented was, "feeling much better, no fever, pain to left leg mostly in AM." It is not clear whether the physician understood that the patient had active endocarditis inadequately treated. Rheumatoid arthritis and pain was not addressed. The anticoagulation was not addressed. At this point, the only medication the patient was on was morphine and aspirin. There was no mention of a prosthetic valve or anticoagulation. The heart was not even auscultated. The only examination consisted of a brief review of the wound. The physician's assessment only included post ischemic leg and did not include his active endocarditis, mechanical valve or rheumatoid arthritis. The patient was documented as having diverted narcotics, and morphine was decreased to 15 mg twice a day and the patient was rescheduled for a two-week appointment. At this point, the medication care plan for this patient was for acetaminophen, low dose aspirin and docusate for a real problem list of endocarditis, mechanical heart valve, concentric heart hypertrophy and rheumatoid arthritis. This was substandard care.

The patient was seen by a physician on 2/22/12. Again, the history was very poor. It did not include mention of anticoagulation and did not mention that the patient had active endocarditis and was being inadequately treated. There was no mention of the rheumatoid arthritis. The physician did document that the patient was referred to a cardiologist on 10/11/11 but had not been seen. This was prior to the Stanford admission. There was no mention that Stanford had recommended a follow-up echocardiogram and cardiology

appointment. The physician documented that there were no records from the Stanford admission. This was the same physician who had been following the patient in this yard for several visits. If he had not had records for six weeks, there was no documented attempt to discover what had occurred to the patient by calling Stanford or discussing with the CTC physician what was wrong with the patient. The same history of ischemic leg and prior endocarditis were documented but none of the current problems was addressed in the history. Except for a description of the wound, four boxes including "cardio" were checked as within normal limits. Again, it is hard to imagine that a person with active endocarditis of a mechanical valve would have normal heart sounds. The physician diagnosed ischemic leg and endocarditis, but it was not clear whether the physician appreciated that the endocarditis was active. The physician requested notes from Stanford and ordered a cardiology follow-up. The anticoagulation was not mentioned, and it was not mentioned that the patient had a prosthetic valve. A 60-day follow-up was ordered. In light of the patient's actual problems, this was not appropriate. The physician noted that the morphine would be discontinued on 2/28/12. The patient was on aspirin. Again, this is substandard care.

On 4/19/12, a physician saw the patient. The physician noted review of the records from Stanford, so there is no question that the physician should have realized that the patient had active endocarditis of a prosthetic valve. However, the physician did not document understanding of the Stanford record, including the active endocarditis, the need for anticoagulation, the prosthetic valve or the subsequent refusal of treatment for the patient's endocarditis at the SVSP CTC. The recommendations for echocardiogram and cardiology were not noted. The history included none of the patient's active problems including endocarditis, mechanical heart valve and anticoagulation or rheumatoid arthritis. Instead, the physician addressed an episodic complaint of the patient. The patient was complaining of a daily headache which kept him up at night with photophobia and nausea with pain to his temples but without blurry vision. The only documented examination of the head and neurological system was a comment that the patient had tenderness over the temporal area. The "cardio" box was checked within normal limits. Remarkably, the physician came up with a diagnosis of giant cell arteritis and ordered high dose prednisone. In light of the patient's actual problems, drawing a conclusion that the patient had giant cell arteritis can only be done by ignoring the patient's actual problems. The physician also noted in the assessment a prior history of endocarditis and mitral valve replacement and history of ischemic leg, but did not reason that the prosthetic valve and vegetations on the valve could be a cause of the headache. This was an extreme departure from logical thinking and a failure to draw conclusions from the patient's actual problems. The physician noted that a cardiologist appointment was scheduled. Notably, for a serious headache, a neurological examination and examination of the fundi were not documented. The physician ordered blood tests and an urgent referral to rheumatology was ordered.

The laboratory test results from 4/19/12 included a high white blood cell count with an increase of the types of white blood cells seen in an infection and an elevated erythrocyte sedimentation

rate (ESR)[148], both of which are indicative of a possible infection. Four days later, on 4/23/12, the physician wrote an addendum to the 4/19/12 note, stating that the neurological examination had been essentially normal and the fundoscopic examination had been normal. He discussed the case with a senior physician, who concurred with the decision to refer the patient to a rheumatologist. The physician added that the ESR was elevated and that this could be giant cell arteritis[149]. The possibility that the elevated white blood cell count and ESR were most likely due to active endocarditis was not considered. The mortality review found that the note and its addendum met standard of care. However, the physician did not consider the patient's actual condition of endocarditis, which was not being adequately treated. Addition of prednisone would further suppress the patient's immune system and could only make his active endocarditis worse. Untreated endocarditis in its natural course can result in emboli which could pass to the brain. The physician's assessment of an uncommon disease, such as giant cell arteritis, failed to consider the obvious. This is poor clinical thinking and a major omission. Also, if the Stanford record were reviewed carefully, the physician should have been made aware of the patient's actual condition. Therefore, this care was substandard.

On 4/24/12, the patient submitted a 7362 request. The handwriting of this request was significantly different and more disorganized than prior requests from this patient. The request stated that he had an extremely bad headache that had been non-stop for 2½ weeks. There was an additional statement about his family that is not intelligible. The request was triaged on 4/23/12, indicating that perhaps the patient was not aware of the correct date. A nursing assessment protocol was performed. The patient described the headache as 9/10 on a pain scale and present for 2½ weeks. It was throbbing, constant, and nothing made it better. This was an emergency. The nurse appropriately notified a physician. The patient was provided Tylenol with codeine and prednisone. A physician did not evaluate the patient. The failure of the physician to evaluate the patient was a serious error of omission. This was noted by the mortality reviewer.

Early the next morning on 4/24/12, a physician telephone note documented that the patient was sent to a local hospital after being found unresponsive. On the Emergency Care Flow Sheet, the patient was described as having severe headache and vomiting. His speech was not comprehensible and he was making unintelligible statements. The admission note at the hospital included a history that the patient had mitral valve replacement but was not anticoagulated. The patient had small unreactive pupils and the CT scan showed a large cerebral hemorrhage with some cortical hemorrhages and some subarachnoid hemorrhages with brain stem compromise. He was ultimately diagnosed with a ruptured mycotic aneurysm. This shortly resulted in his death.

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[148] The ESR is a non-specific marker of acute or chronic inflammation.

[149] Giant cell arteritis is an inflammation of the lining of the arteries. Most often, it affects the arteries in your in the temples and can cause headaches.

The patient remained in general population for over four months. He had a life-threatening infection of his heart valve being treated with an ineffective antibiotic regimen. This basically meant that the patient remained untreated for four months and the natural course of an untreated condition took its toll on the patient.

The CCHCS Death Review Committee ruled this death possibly preventable. We agree. The Death Review Committee did identify some problems with care of this patient. They did not identify that there was failure to anticoagulate this patient prior to admission to Stanford, even though the patient had a biosynthetic mitral valve. They did not identify that the type of cardiac valve was not accurately identified by SVSP. They did not identify that the patient probably was injecting drugs which may have resulted in his endocarditis, and that physicians prescribed morphine to him without good indication. They failed to identify that the follow-up of endocarditis after the Stanford admission was substandard care. Even though the patient refused antibiotics, the physicians abruptly stopped monitoring endocarditis as an active problem. The failure to recognize that the patient had active endocarditis for that last four months of life without notice by any primary care physician was substandard care and a serious error of omission. Similarly, the failure to anticoagulate this patient with a prosthetic heart valve was also substandard care.

The third death[150] involved a patient with late-stage cirrhosis with multiple complications of his cirrhosis. This patient's death was not preventable. We mostly agree with the assessment of the CCHCS mortality review. Particularly, we note that they identify many of the recurring problems with physician practice at this facility that we have identified in this report, validating our findings of inadequate physician care. This also places focus on the peer review process and the apparent ineffectiveness of this process at this site.

Over a 10-month period of review, the patient had 13 TTA visits and three hospitalizations, but only five primary care visits. His care was mostly managed by emergency evaluation. His major problems were not carefully managed in primary care and therefore the patient placed numerous 7362 slips for emergency-type issues. This demonstrates a failure of primary care. This patient probably needed to have been housed on the CTC unit given his condition.

During the 10 months of our review, the patient was on a continuous high dose of morphine without a clinical indication and without ever having a history or physical examination to establish the need for narcotic medication. One example of the type of evaluation that occurred with respect to morphine was a physician statement that the patient was "able to handle current narcotic dose." There was no history or physical examination establishing the extent of pain and the indication for morphine was not documented in this encounter. It was irresponsible care allowing the patient to decide whether to receive morphine without indication. In the 11/23/11 primary care visit, morphine was increased without a history or

[150] Mortality Review Patient #3.

physical examination identifying any painful condition or indication. This is substandard care and not in keeping with Medical Board of California guidelines for narcotic prescribing.

Lactulose is a medication that promotes diarrhea and is used to reduce ammonia absorption, which prevents hepatic encephalopathy in patients with cirrhosis. This drug is titrated to ensure that bowel movements are not excessive because excessive use of Lactulose can result in the patient soiling himself or herself. Over the 10-month period, none of the primary care notes for this patient included a history of the number of bowel movements the patient had related to the dose of Lactulose. Yet, on a number of occasions, the patient complained of soiling himself from diarrhea. This was indifferent and substandard care.

There were a multitude of inadequate episodes of care, many of which were identified by the CCHCS mortality review as well. These include failure of physicians to document notes after a patient evaluation; failure to see the patient on a scheduled day of appointment; failure to note diagnosis (diabetes) made at the hospital when the patient returned to the facility; failure to perform a physical examination on a disability evaluation; performing physician visits without taking a history from the patient; failing to document clinical reasoning in making assessments; failing to follow up on laboratory tests; failure to follow up on a complaint of rectal bleeding; failure of a nurse to refer a patient with abnormal vitals and edema; failure of a physician to evaluate a patient with altered mental status; poor clinical reasoning by a physician when examining the patient when the patient had altered mental status; performing a substandard evaluation for chest pain in the TTA; and failure to consistently identify all of the patient's problems when the patient was examined.

Because most of this patient's care took place in the TTA, it became his de facto primary care location. However, care in the TTA was not good. The 8/28/12 TTA evaluation was indifferent and substandard. The patient had nausea, upset stomach and chest tightness. The physician wrote, "Pt seen by me multiple times. EKG unchanged. No acute changes. Rx MS 30 IR po now." This was a phone interview but nevertheless drew a conclusion without a history. No diagnosis was actually made. There was no clinical indication for the 30 mg of morphine. If the patient had chest pain from heart disease, it could have resulted in harm to the patient. On 9/8/12, the patient was seen in the TTA for abdominal pain and cramping. The physician made fun of the patient by saying that he had candy bars falling out of his pockets. Whether the patient was eating candy bars or anything else did not mean that he did not also have abdominal pain. This was an unprofessional note. On 9/14/12, the patient complained of nausea, vomiting and diarrhea. He was seen in the TTA and the physician documented that the patient had chest pain and that the patient had previously been sent out and had non-cardiac chest pain. There was almost no history pertinent to nausea, vomiting, diarrhea or chest pain except to state that the patient had no diaphoresis. An EKG was done. This was a substandard cardiac evaluation for a patient with a complaint of chest pain. Because similar episodes of care have already resulted in monitoring of several physicians at this site, we worry that the monitoring and mentoring is ineffective and repeating monitoring over and over needs to be replaced by accountability for indifferent or substandard care.

Finally, for this patient we note that communication regarding his end of life wishes was inconsiderate and ineffective. For example, the 8/8/12 hospice evaluation had boxes checked that the patient wanted and did not want life-sustaining measures. Given that the patient on several occasions stated that he wanted to change his DNR status, it appears that there was very poor and ineffective communication with this patient about end of life decisions. It is the responsibility of a health care organization to ensure that the patient's desires are adhered to.

Internal Monitoring and Quality Improvement Activities

Methodology: We reviewed the SVSP OIG report, facility Primary Care Assessment Tool, Performance Improvement Work Plan (PIWP), and internal monitoring and quality improvement meeting minutes, including Emergency Medical Response Review Committee, Infection Control, and Pharmacy and Therapeutics Meeting minutes.

Findings: Although we recognize that some meaningful quality improvement activities are being conducted (e.g. medication expiration reports, etc.), taken as a whole, there is no meaningful quality improvement program at SVSP.

We reviewed Quality Management Committee Meeting minutes from 1/23/13 to 5/6/13. To read the minutes, one would think that SVSP had no significant problems related to timeliness or quality of health care services. At the 2/13/13 QMC committee meeting, the Pharmacy and Therapeutics (P&T) subcommittee reported that there were no medication errors reported from October to December 2012. This means that there is no effective system for reporting medication errors, but this was not recognized and addressed. At the conclusion of the P&T subcommittee report, there were essentially no identified problems, recommendations or action items to be taken.

The Monthly Program Management Report Subcommittee reported that only 50% of patients referred by the nurse to the PCP were seen within the 14 day requirement. There was no root cause analysis, discussion, recommendations, or action items related to this information.

Emergency Medical Response Review Committee (EMRRC) reported the number of emergencies and deaths in November and December, but there were no recommendations or outstanding action items.

The Health Care Access Quality Report provided statistics regarding access to care but no discussion regarding their relevance and no recommendations or actions items. We do note however, that there were dental and mental health subcommittee minutes that provided meaningful discussion of issues.

We reviewed Pharmacy and Therapeutics Meeting minutes for July and August 2012 and February 2013, which were all that was provided to us. These meetings are focused almost solely on medication errors, of which very few are reported. Relative to the problems we identified during our review, the content of the meetings are lacking in substance. Nursing services and pharmacy have collaborated to perform studies related to expiration of

medication orders in order to prevent chronic disease medication orders from lapsing, and this is to be commended. We would recommend that these studies be included in P&T meeting minutes, root causes investigated and action plans developed to address root causes.

Review of EMRRC meeting minutes focuses almost solely on timeliness of response to emergencies. There is no review of whether care provided prior to the urgent event was appropriate and whether improvements can be made to prevent future emergencies.

We reviewed Infection Control Meeting minutes from 1/15/13 to 4/19/13. The minutes present items of concern (e.g., blood and feces found in the laundry, garbage found in biohazardous red bags, etc.), data to infections and whether they are health care or community acquired infections and tuberculin skin testing, etc. There is also reporting of the number of exposures to blood-borne pathogens but no discussion of how they occurred and what could be done, if anything, to prevent future exposures. In general, there is little discussion or analysis of the data or findings related to infection control. With respect to health care associated infections, there is no discussion of possible root causes or epidemiological linkages between infections.

In summary, the infection control program needs further development to be an effective program.

Recommendations

Operations: Budget, Equipment, Space, Supplies, Scheduling, Sanitation, Health Records, Laboratory, Radiology

1. CCHCS should standardize clinic design and ensure it is implemented statewide.
2. A Periodic Automatic Replenishment (PAR) system should be put into place.
3. A 5S[151] method of standardizing clinics and removing of clutter should be instituted at this facility.
4. SVSP health care and custody leadership should ensure that a schedule of sanitation and disinfection activities is developed, implemented and monitored. In light of ongoing sanitation and infection control issues, CCHCS and CDCR should reevaluate the model of having inmate porters assigned sanitation and disinfection duties in medical areas.
5. CCHCS should reevaluate statewide credentialing and peer review policies and procedures and take measures to ensure that they are uniformly implemented in all CDCR facilities. The requirements of the 2008 Court Order should be clearly reflected in the statewide and local policies.
6. Credential, peer review and performance review documents should be maintained for all physicians for the entire span of employment for each physician.
7. Procedures and file management at PPEC offices should be evaluated.
8. PPEC should maintain on file all reports and notifications required by the Court-ordered physician peer review procedure.

Intrasystem Transfer

1. As recommended in previous reports, we recommend that CCHCS revise the 2010 policy regarding the health care transfer process and clarify expectations regarding timeframes for provider referral following transfer. We recommend that patients identified as having a significant medical condition (e.g., high risk, chronic disease, recent hospitalization or specialty services consultation/procedure) be seen by a medical provider within 7-14 days of arrival to ensure that continuity of care is provided.

2. CCHCS should provide more clear guidance regarding use of the Medical Hold, including not transferring patients who have scheduled specialty services appointments within days of being transferred.

[151] 5 S is the name of a workplace organization method used in lean manufacturing methods. The 5 S phases consist of sorting, set in order, systematic cleaning, standardizing and sustaining.

3. Prior to transfer of patients from a medical bed (e.g., OHU, CTC or GACH), there should be physician to physician communication to ensure that appropriate and timely care is provided.
4. For all new arrivals, nurses should obtain a complete set of vital signs and weight, and document the time frame for referral.
5. Physicians should thoroughly review the patient's eUHR upon arrival to become familiar with the patient's medical history. Physicians should clinically evaluate patients prior to discontinuation of chronos or medications, and develop an alternate treatment plan with the patient.

Access to Care

1. SVSP health care leadership should ensure that nurses triaging 7362s related to dental pain and/or urgent mental health concerns should either evaluate patients or coordinate with dental and mental health services to ensure patients are seen in a timely manner.
2. SVSP health care leadership should provide nurses additional training regarding health assessments, including obtaining an adequate history and performing physical examinations.
3. CCHCS nursing leadership should review and revise the nursing protocols to ensure that they adequately guide the nurse in evaluating patient health complaints.
4. SVSP health care leadership should continue to monitor timeliness of nurse to physician referrals and address root causes of delays.

Chronic Disease Management

1. CCHCS should work to finalize pain management guidelines and implement these at SVSP and ensure that they are consistent with the California Medical Board guidelines.
2. CCHCS should determine whether failure to follow appropriate California Medical Board guidelines related to pain management is a reportable infraction to the Medical Board.
3. CCHCS should initiate an evaluation at SVSP of the procurement, storage, and use of narcotics at this facility.

Pharmacy and Medication Administration

1. Upon arrival, an SVSP physician should review the patient's medication reconciliation report and determine which medications should be reordered.
2. Pharmacy services should not, based on a standing order, substitute formulary for non-formulary medications without consulting with a physician.
3. Physicians should not order the pharmacy to taper medications without documenting an order that contains all elements of a legal order (name, dose, duration, etc.).

4. Nursing and pharmacy services should collaborate to develop a more robust system for reporting medication errors in order to study root causes and develop an effective action plan.
5. We strongly recommend that pharmacy services find and purchase acetaminophen packaging with less than 100 tablets for distribution by nurses via protocol.

Health Records

1. SVSP Health care leadership should ensure that health record documents are obtained, reviewed, and signed into the eUHR in a timely manner. This includes laboratory, specialty services and hospitalization reports.

Specialty Services

1. SVSP leadership should correct the problems with the system for scheduling on- and off-site specialty visits.
2. SVSP should identify and correct the issues related to timely and appropriate follow-up of specialty visits.

Specialized Medical Housing: OHU/CTC/GACH

1. Statewide nursing leadership should evaluate nurse treatment plans and attempt to collaborate with physicians on development of effective treatment planning for patients on higher level of care units. This would be particularly helpful in advance of the opening of the Stockton facility.
2. Providers should dictate notes on this unit.
3. Problem lists should be used and contemporaneously maintained on the CTC unit.
4. In their assessments, providers should address all of a patient's active medical problems, including therapeutic plans, pending appointments and other interventions.
5. Management at SVSP should perform a root cause analysis to discover why medical record documents are not found on CTC charts and take appropriate corrective action.
6. In light of the fact that SVPP is operating under the SVSP CTC license, CCHCS should reevaluate its administrative relationship with SVPP and ensure that the facility meets CTC licensure requirements. If the current arrangements with the Department of State Hospitals are to continue, then CTC policies must reflect this relationship. If it is not feasible for CCHCS to ensure SVPP compliance with licensure requirements, consideration should be given to requiring that SVPP to obtain independent licensure.
7. SVSP must correct its CTC policies to ensure that they are consistent with the 2008 Court order regarding physician clinical competency.

Mortality Review

1. Autopsies should be performed for every death.

2. CCHCS should undertake a review of the mortality review process. Court Experts would like to participate in an evaluation of the review process. Review of the process should result in:
    a. Involvement of local institutional leadership in performing the initial mortality review or collaborating in a meaningful way on mortality review.
    b. Integration of the corrective action plan into the Quality Improvement Program at the institutional level.
    c. Establishment of procedures for follow-up of corrective action plans.
    d. Identification of responsible Central Office staff for ownership of CCHCS system-wide identified problems and a mechanism to report on progress of corrective action.
    e. Incorporation of professional practice issues into staff training and continuing education.