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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

June 2023

Cycle 6 Medical Inspection Report

California City Correctional Facility

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Introduction

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

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

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

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

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

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

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

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

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

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

As we did during Cycle 5, our office is continuing to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of the California City Correctional Facility (CAC), the institution had been delegated back to the department by the receiver.

We completed our sixth inspection of CAC, and this report presents our assessment of the health care provided at this institution during the inspection period from November 2021 to April 2022.[6] The data obtained for CAC and the on-site inspections occurred during the COVID-19 pandemic.[7]

Located in California City, in Kern County, the California City Correctional Facility (CAC) opened in 2013. CAC primarily houses medium-security Level II and general population inmates. The institution operates multiple medical clinics where medical staff members handle nonurgent requests for medical services. In addition, CAC operates a triage and treatment area (TTA) for urgent or emergent patient care, a receiving and release (R&R) clinic for assessment of arriving and departing patients, and a specialty clinic. CAC does not have a specialized medical housing unit. CCHCS has designated CAC as a *basic health care institution*. Basic care institutions are located in rural areas away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include emergency cardiopulmonary (CPR) reviews between May 2021 and July 2021, death reviews between March 2021 and August 2021, transfer reviews between August 2021 and February 2022, and registered nurse (RN) sick call reviews between November 2021 and May 2022.

[7] As of February 21, 2023, the department reports on its public tracker that 71% of its incarcerated population at CAC is fully vaccinated while 62% of CAC staff are fully vaccinated: http://www.cdcr.ca.gov/covid19/population-status-tracking/.

Summary

We completed the Cycle 6 inspection of CAC in October 2022. OIG inspectors monitored the institution's delivery of medical care that occurred between November 2021 and April 2022.

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

Table 1. CAC Summary Table

Ratings

Proficient *Adequate* *Inadequate*

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

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

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

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

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 323 patient records and 980 data points and used the data to answer 83 policy questions. In addition, we observed CAC processes during an on-site inspection in July 2022. Table 2 below lists CAC average scores from Cycles 4, 5, and 6.

Table 2. CAC Policy Compliance Scores

Scoring Ranges

100%–85.0% | 84.9%–75.0% | 74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score Cycle 4	Cycle 5	Cycle 6
1	Access to Care	87.9%	94.6%	75.5%
2	Diagnostic Services	77.3%	75.6%	62.2%
4	Health Information Management	87.2%	92.0%	85.9%
5	Health Care Environment	86.4%	87.0%	31.1%
6	Transfers	94.8%	85.2%	74.9%
7	Medication Management	92.1%	87.2%	49.7%
8	Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*
9	Preventive Services	95.0%	92.7%	75.6%
12	Reception Center	*N/A*	*N/A*	*N/A*
13	Specialized Medical Housing	*N/A*	*N/A*	*N/A*
14	Specialty Services	88.6%	96.9%	66.5%
15	Administrative Operations	63.5%*	85.0%	77.4%

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

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

The OIG clinicians (a team of physicians and nurse consultants) reviewed 35 cases, which contained 685 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in October 2022 to verify their initial findings. The OIG physicians rated the quality of care for 18 comprehensive case reviews. Of these 18 cases, our physicians rated none ***proficient***, 17 ***adequate***, and one ***inadequate***.

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

In June 2022, the Health Care Services Master Registry showed that CAC had a total population of 2,034. A breakdown of the medical risk level of the CAC population as determined by the department is set forth in Table 3 below.[9]

Table 3. CAC Master Registry Data as of June 2022

Medical Risk Level	Number of Patients	Percentage*
High 1	3	0.1%
High 2	13	0.6%
Medium	275	13.5%
Low	1,743	85.7%
Total	**2,034**	**100.0%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 6-13-22.

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

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

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, CAC had 1.0 vacant executive leadership position, no primary care provider vacancies, 0.5 nursing supervisor vacancies, and 8 nursing staff vacancies.

Table 4. CAC Health Care Staffing Resources as of May 2022

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	4.0	4.0	11.5	65.0	84.5
Filled by Civil Service	3.0	4.0	11.0	57.0	75.0
Vacant	1.0	0	0.5	8.0	9.5
Percentage Filled by Civil Service	75.0%	100.0%	95.7%	87.7%	88.8%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0	0	1.0	1.0
Percentage Filled by Registry	0	0	0	1.5%	1.2%
Total Filled Positions	3.0	4.0	11.0	58.0	76.0
Total Percentage Filled	**75.0%**	**100.0%**	**95.7%**	**89.2%**	**89.9%**
Appointments in Last 12 Months	0	0	2.0	26.0	28.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	1.0	0	0	1.0	2.0
Adjusted Total: Filled Positions	**2.0**	**4.0**	**11.0**	**57.0**	**74.0**
Adjusted Total: Percentage Filled	**50.0%**	**100.0%**	**95.7%**	**87.7%**	**87.6%**

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 6 medical inspection preinspection questionnaire received on May 31, 2022, from California Correctional Health Care Services.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An adverse event occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10] The OIG did not find any adverse events at CAC during the cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed nine of the 12 indicators applicable to California City Correctional Facility. Of these nine indicators, OIG clinicians rated eight ***adequate*** and one ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 18 detailed case reviews they conducted. Of these 18 cases, none were ***proficient***, 17 were ***adequate***, and one was ***inadequate***. In the 685 events reviewed, there were 186 deficiencies, 21 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at CAC:

- Staff provided good access to providers and nurses during the review period, including follow-up appointments after specialty services and hospitalizations.
- Providers generally managed chronic conditions well.

Our clinicians found the following weaknesses at CAC:

- Providers did not always provide a subjective and objective write-up in their documentation of patient encounters.
- Providers did not always communicate test results with all the required elements in patient notification letters.
- The institution did not always provide laboratory services within required time frames.

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

Compliance Testing Results

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

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

- The institution timely scanned requests for health care services into patients' electronic medical records and community hospital discharge reports within the required time frames.
- CAC offered influenza vaccinations, provided colorectal cancer screening, and administered tuberculosis (TB) medications to all sampled patients timely.
- Nursing staff reviewed health care services request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames.

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

- Medical clinics at CAC did not meet requirements for essential core medical equipment and supplies. Almost all clinics tested were missing properly calibrated medical equipment and medical supplies required to provide standard medical care.
- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.
- Medication nurses did not properly demonstrate appropriate administrative controls and protocols in medication line areas. In addition, medication nurses did not maintain proper hand hygiene while distributing medications to patients.
- CAC did not perform well in ensuring that preapproved specialty services for patients arriving at CAC, and high-priority specialty services, were provided timely. Furthermore, CAC often did not ensure specialty service reports were received timely.
- The institution performed poorly in providing laboratory services within the required time frame. Moreover, patient letters communicating diagnostic test results were missing key elements required by CCHCS policy.

Population-Based Metrics

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

HEDIS Results

We used population-based metrics in considering CAC's performance to assess the macroscopic view of the institution's health care delivery. We list the applicable HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—CAC performed better in the one diabetic measure that has statewide comparative data: poor HbA1c control.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include this data for informational purposes. CAC had a 55 percent influenza immunization rate for adults 18 to 64 years old, but an insufficient sample size to determine the influenza immunization rate for adults 65 years of age and older.[11] The pneumococcal vaccine rate also had an insufficient sample size.[12]

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

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

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. CAC had an 82 percent colorectal cancer screening rate.

Table 5. CAC Results Compared With State HEDIS Scores

HEDIS Measure	CAC Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (>9.0%)‡,§	**6%**	42%	34%	23%
HbA1c Control (<8.0%)‡	88%	–	–	–
Blood Pressure Control (<140/90)‡	84%	–	–	–
Eye Examinations	43%	–	–	–
Influenza–Adults (18–64)	55%	–	–	–
Influenza–Adults (65+)‖	N/A	–	–	–
Pneumococcal–Adults (65+)‖	N/A	–	–	–
Colorectal Cancer Screening	82%	–	–	–

Notes and Sources

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

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2020–June 30, 2021 (published April 2022); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/EQRTechRpt-Vol1.pdf**.

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

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

‖ For this measure, the scoring was not applicable due to the sample yielding a total population of fewer than 10 patients.

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

Recommendations

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

Access to Care

- Medical leadership should determine the root cause(s) of challenges in timely providing chronic care follow-up appointments, transfer-in provider appointments, high-priority specialty appointments, and specialty follow-up appointments with the provider and should implement remedial measures as appropriate.

Diagnostic Services

- The department should consider developing an electronic solution to ensure that providers create patient letters at the time of endorsement and that the patient results letter automatically populates accurately with all required elements per CCHCS policy.
- Medical leadership should ascertain causative factors related to the untimely provision of laboratory services and implement remedial measures as appropriate.
- Medical leadership should determine the root cause(s) of challenges in receiving pathology reports timely and implement remedial measures as appropriate.

Emergency Services

- The department should consider methods to ensure vital signs are monitored and automatically populated into patients' electronic health records.
- The institution should consider basic life support (BLS) remedial training and performance monitoring.

Health Information Management

- Medical leadership should determine the root cause of challenges in retrieving specialty consultations and pathology reports, and institute corrective action as needed.
- Medical leadership should ensure patients receive timely communication of pathology results.
- Medical leadership should determine the root cause of challenges to properly scan, label, and include medical records in the correct patients' files and institute corrective action as needed.

Health Care Environment

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

Transfers

- Health care leadership should identify the challenges to medication continuity for patients returning from hospitalizations or emergency rooms; leadership should implement remedial measures as appropriate.
- Nursing leadership should educate nursing staff on the requirements for documenting an initial health screening.
- Medical leadership should ensure that patients receive their previously scheduled specialty appointments, when transferred, within the required time frame.

Medication Management

- Medical and nursing leadership should ensure that chronic care, hospital discharge, and en-route patients receive their medications timely and without interruption; leadership should implement remedial measures as appropriate.
- Nursing leadership should consider reminding nursing staff to document patient refusals in medical administration records, as described in CCHCS policy and procedures.

Preventive Services

- Nursing leadership and the public health nurse should educate nursing staff on properly documenting tuberculosis (TB) signs and symptoms when monitoring patients who are taking TB medications.

Provider Performance

- Medical leadership should ensure that providers include subjective and objective patient care data in all patient encounters as per policy.

Specialty Services

- Medical leadership should determine the root cause(s) of challenges to the timely provision of specialty appointments and should implement remedial measures as appropriate.

- Medical leadership should ascertain the challenges in the timely receipt, and the provider review, of specialty reports, and implement remedial measures as appropriate.

Access to Care

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
***Adequate* (75.5%)**

Results Overview

CAC provided sufficient access to care in this cycle. Case review and compliance found that providers and nursing generally saw the patients within required time frames. In contrast, in compliance testing, CAC struggled with timely providing provider follow-up appointments for chronic care and newly transferred patients, as well as high-priority specialty appointments. After reviewing all aspects of access to care, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 123 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. We identified four deficiencies, two of which were significant.[13]

Access to Care Providers

CAC's performance was mixed in providing access to provider-ordered follow-up appointments. Compliance testing showed poor access to chronic care follow-up appointments with providers (MIT 1.001, 60.0%), but good access to providers from nurse referrals (MIT 1.005, 90.0%).

OIG clinicians noted that both in-person provider appointments and chart reviews were utilized for patient care. Case review clinicians found one deficiency related to nurse-ordered provider appointments and no deficiencies in completing provider-ordered provider appointments. The following is an example of a significant deficiency:

- In case 11, nursing staff assessed the patient for a sick call and ordered a provider follow-up to occur within 14 days; however, the appointment did not occur during the review period.

[13] Deficiencies occurred in cases 6, 7, 11, and 28. Cases 6 and 11 had significant deficiencies.

Access to Clinic Nurses

CAC performed excellent in access to nursing sick calls and provider-to-nurse referrals. Compliance testing found that nurses reviewed the patient's request for services on the same day (MIT 1.003, 100.0%), and completed face-to-face visits within one business day after a sick call request was placed (MIT 1.004, 96.7%). Our clinicians assessed 44 nursing sick call requests and identified one deficiency related to clinic nurse access.[14]

Access to Specialty Services

CAC had a mixed performance in specialty services. Compliance testing determined there was very good completion rates of medium-priority and routine-priority appointments, but a poor completion rate of high-priority appointments (MIT 14.004, 100%, MIT 14.007, 86.7%, and MIT 14.001, 53.3%). Specialist follow-up appointments generally occurred timely for high-priority, medium-priority, and routine-priority services (MIT 14.003, 88.9%, MIT 14.006, 75.0%, and MIT 14.009, 75.0%). Case review clinicians found most specialty appointment took place within requested time frames; we identified only one deficiency.[15]

Follow-Up After Specialty Services

Compliance testing revealed that 73.2 percent of provider appointments after specialty services occurred within the required time frame (MIT 1.008). OIG clinicians reviewed 44 specialty service events and identified one significant deficiency related to provider follow-up:

- In case 6, the nurse ordered a specialty follow-up appointment with the provider, which did not occur as ordered.

Follow-Up After Hospitalization

CAC performed very well with ensuring that providers saw patients after hospitalizations (MIT 1.007, 93.3%). Case review did not identify any appointment deficiencies related to provider follow-up after hospitalization.

Follow-Up After Urgent or Emergent Care (TTA)

Providers generally saw their patients following a triage and treatment area (TTA) event as requested. OIG clinicians assessed three TTA events and did not identify any missed or delayed appointments.

[14] A deficiency occurred in case 28.

[15] A deficiency occurred in case 7.

Follow-Up After Transferring Into the Institution

Access to care for patients who had recently transferred into the institution was mixed. Compliance testing showed poor access to intake appointments for newly arrived patients (MIT 1.002, 50.0%). Case reviewers did not find any deficiencies in this area; however, we reviewed only seven cases in which patients transferred from another institution.

Clinician On-Site Inspection

CAC had three main clinics: A, B, and C. All three clinics were located within the main medical area of the institution, and each clinic had one to two providers. Our case review clinicians spoke with CAC's executive leadership, medical and nursing leadership, and schedulers regarding the institution's access to care. The scheduling supervisor explained that most of the delayed or missed appointments were related to the COVID-19 pandemic or due to offsite specialists' schedules. CAC's review period took place during the COVID-19 pandemic.

The OIG clinicians attended the Clinic A morning huddle, which was designated as the main huddle. The Clinic A huddle was well-attended by all three clinic patient care teams. The scheduling supervisor reported that he attended the huddles and that provider appointments were generally met. CAC operated a TTA and specialty clinic that offered audiology, physical therapy, optometry, ophthalmology, ultrasound, fibroscan, and orthotic services.

Compliance Testing Results

Compliance On-site Inspection and Discussion

Patients had access to health care services request forms at only one of six housing units inspected (MIT 1.101, 16.7%). We found the following deficiencies in five inspected housing units: there were no available Health Care Request for Services forms (CDCR form 7362), and custody did not have a system in place for procuring this critical form. Custody officers reported relying on inmate clerks or medical staff to replenish the form in the housing units.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	15	10	0	60.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	12	12	1	50.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	29	1	0	96.7%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	9	1	20	90.0%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	1	0	29	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	14	1	1	93.3%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	30	11	4	73.2%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	1	5	0	16.7%
			Overall percentage (MIT 1): **75.5%**	

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

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

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

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	N/A	N/A	N/A	N/A
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	N/A	N/A	N/A	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	1	6	88.9%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	2	7	75.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	3	1	11	75.0%

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

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

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges in timely providing chronic care follow-up appointments, transfer-in provider appointments, high-priority specialty appointments, and specialty follow-up appointments with the provider and should implement remedial measures as appropriate.

Diagnostic Services

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

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (62.2%)**

Results Overview

CAC performed worse in Cycle 6, compared with Cycle 5. In Cycle 6, case review found that the institution generally performed diagnostic tests on time and the providers performed well in reviewing and communicating the results to the patient within the required time frame. Compliance testing showed that radiology services were completed on time and that providers reviewed radiology and laboratory results timely. However, compliance testing found that CAC staff did not perform laboratory services timely, and the providers did not communicate the results of radiology and laboratory tests within required time frames. In addition, compliance testing revealed that the institution did not always retrieve final pathology reports, and the provider did not communicate pathology results timely. After reviewing all aspects of diagnostic services, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 218 diagnostic events and found 69 deficiencies, three of which were significant. Of these 69 deficiencies, we found 46 of them were related to health information management, 22 pertained to delayed or noncompletion of ordered tests, and one was due to a lack of follow-up for a STAT laboratory result.[16]

For health information management, we consider test reports that were never retrieved or reviewed to be as severe a problem as tests that were never performed. This is discussed further in the **Health Information Management** indicator.

Test Completion

CAC performed excellently in completing radiology services (MIT 2.001, 100%), but poorly in completing laboratory services (MIT 2.004, 20.0%) within required time frames. There were no compliance STAT laboratory samples available during our testing period (MIT 2.007, N/A). Case review found 22 deficiencies

[16] Deficiencies occurred in cases 6–9, 13, 14, 16, 17, 19, and 20. Cases 14 and 19 had significant deficiencies.

related to diagnostic tests that were not performed timely, none of which were considered significant.[17] Below are two examples of these deficiencies:

- In case 8, the provider ordered several blood tests; however, the blood sample was collected 13 days late.
- In case 20, the provider ordered a COVID-19 PCR nasal swab; however, the nasal swab specimen was collected three days late.

Health Information Management

CAC's performance with health information management was variable in quality. Staff retrieved laboratory and diagnostic results promptly and sent them to providers for review. Compliance testing showed that providers endorsed both radiology (MIT 2.002, 100%) and laboratory (MIT 2.005, 90.0%) results timely. The compliance team also determined that providers reviewed and endorsed pathology reports within specified time frames (MIT 2.011, 100%). In contrast, staff did not perform satisfactorily with pathology report retrieval (MIT 2.010, 70.0%), and providers performed poorly with communicating pathology results to the patient (MIT 2.012, zero). Compliance testing had no STAT results to review for MIT 2.008. The case review team had one deficiency related to a STAT result as described below:

- In case 14, the provider ordered STAT laboratory tests to evaluate the patient's rectal bleeding. However, the health care team did not promptly follow-up on the STAT laboratory test results.

The OIG clinicians identified 69 deficiencies, most of which were related to health information management. They involved results notification letters that were incomplete or were not completed (44 out of 69).[18] The following are examples:

- In case 18, the provider endorsed laboratory results, but did not create a patient notification letter in the patient's electronic health record.
- In case 20, the provider sent a patient notification letter, which did not include whether the results were within normal limits as per policy.

Clinician On-Site Inspection

We interviewed the diagnostic services supervisor and the radiology technician. They reported providing basic X-ray, ultrasound, and fibroscan tests on site. The radiology technician stated there were no backlogs. The diagnostic services supervisor reported that in September 2021, all laboratory staff had either been promoted or left the institution. The supervisor also reported having a lack of

[17] Deficiencies related to test completion occurred in cases 6–9, 13, 16, 17, 19, and 20.

[18] Deficiencies occurred in cases 1, 5–11, 13, 14, and 17–20.

registry staff. As a result of insufficient staffing, nurses began performing blood draws needed to complete laboratory tests, and staff from other institutions also assisted in completing laboratory blood draws. The supervisor reported experiencing a recruitment challenge, stating that it was difficult to hire laboratory staff due to low pay. The supervisor also pointed to processing COVID-19 swabs, ISUDT urine toxicology screens, and hepatitis C laboratory tests as factors that all had increased the workload of the diagnostics department's staff.[19] Despite these challenges, medical staff did not report any issues with completing weekday and weekend routine or STAT laboratory tests.

[19] ISUDT is the Integrated Substance Use Disorder Treatment program.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	7	3	0	70.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	2	8	0	20.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	0	1	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
				Overall percentage (MIT 2): **62.2%**

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

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

Recommendations

- The department should consider developing an electronic solution to ensure that providers create patient letters at the time of endorsement and that the patient results letter automatically populates accurately with all required elements per CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely provision of laboratory services and implement remedial measures as appropriate.

- Medical leadership should determine the root cause(s) of challenges in receiving pathology reports timely and implement remedial measures as appropriate.

Emergency Services

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Results Overview

CAC performed poorly in emergency services. In Cycle 6, OIG clinicians identified more deficiencies than were identified in Cycle 5. In Cycle 5, we identified CAC's pattern of incomplete documentation. Unfortunately, this pattern continued in Cycle 6. We also identified patterns of practice that could lead to harm. Nurses did not always provide appropriate emergency care, related to basic life support (BLS) cardiopulmonary resuscitation (CPR). Nurses' BLS assessments and interventions were deficient, and nurses did not prioritize AED placement when their patients were pulseless. In addition, CAC's quality review process did not identify its nurses' deficiencies. Subsequently, opportunities to provide staff with training and education were also missed. Considering all the above issues, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 17 urgent and emergent events and identified 20 deficiencies. Of these 20 deficiencies, six were significant.[20]

Emergency Medical Response

CAC custody and health care staff responded to emergencies throughout the institution. We did not identify any delays in CAC response times.

Cardiopulmonary Resuscitation (CPR) Quality

In CPR, *basic life support* (BLS) refers to a set of emergency procedures that are performed to help sustain life in a person experiencing cardiac or respiratory arrest. The BLS sequence is important because it provides the first line of care for a person in a life-threatening emergency, and it can make the difference between

[20] Deficiencies occurred in cases 1–6, and 17. Cases 1, 3, 4, and 5 had significant deficiencies.

life and death.[21] Early automated external defibrillator (AED) placement and analysis can greatly increase the chance a person will live by restoring the heart's normal rhythm, increasing the chances of survival, and reducing the risk of permanent damage to the heart and lungs. Time is of the essence, as the chances of survival decrease significantly with every minute that passes. The administration of Naloxone should not delay the initiation of CPR in a suspected opioid overdose, as CPR should be started immediately, regardless of the suspected cause.[22]

At CAC, custody staff frequently initiated CPR and administered Naloxone. During our review, we identified three cases in which CPR was initiated. CAC custody and health care staff initiated CPR when warranted. However, we identified that the nurses did not prioritize AED placement. In addition, when patients had a return of spontaneous circulation, nurses did not always perform a thorough assessment and provide sufficient monitoring.[23] The following list provides examples:

- In cases 3, 4, and 5, health care staff performed CPR, and patients had a return of spontaneous circulation. However, the nurses did not sufficiently assess and monitor their patients.

- In case 3, custody staff initiated CPR, and the first medical responder, a registered nurse (RN), promptly arrived to assess the patient. However, the nurse did not assess the patient for a carotid or femoral pulse. Instead, the nurse inappropriately checked the patient's arm for a pulse. The nurse documented the patient had a very low oxygen saturation level, but did not place an advanced airway.[24] When the patient had a return of spontaneous circulation, the nurses did not closely monitor the patient's vital signs.

- In case 5, custody staff initiated CPR. The first medical responder RN did not provide appropriate basic life support to the patient; instead, the nurse administered several doses of Naloxone to the patient. However, the nurse should have applied an AED to the patient for analysis. An AED was not applied to the patient for 18 minutes.

[21] The BLS sequence includes steps such as performing CPR, using an automated external defibrillator (AED), and providing rescue breathing to a person who is not sufficiently breathing or does not have a pulse. The timely and correct performance of these procedures can help to restore circulation and breathing, and improve the person's chance of survival.

[22] Naloxone is a medication used for the emergency treatment of known or suspected opioid overdose.

[23] Return of spontaneous circulation is the resumption of a sustained heart rhythm that perfuses the body after cardiac arrest. Clinically, the health care provider will identify a central pulse.

[24] An advanced airway is a device that is used or inserted in the nose or mouth that assists in providing adequate oxygenation and ventilation as part of resuscitation efforts.

Provider Performance

Providers performed well in urgent and emergent situations, and for after-hours care. Our clinicians found one provider deficiency related to documentation.

Nursing Performance

Nurses showed opportunities for improvement in BLS CPR-related care. In addition, nurses did not always assess and sufficiently monitor their patients.

- In case 1, the patient was in COVID-19 isolation with chest discomfort and complained of blood in their sputum; however, the TTA RN did not assess the patient's vital signs, inspect the patient's throat, or listen to lung sounds. Instead, the RN inappropriately advised the patient that coughing up a little bit of blood was not significant.

- In case 2, the patient had a loss of consciousness and a possible seizure. The TTA RN did not reassess the patient's vital signs and mental status until emergency medical services personnel arrived.

- In case 17, the patient had severe abdominal pains, and a provider ordered a higher level of care. For 75 minutes, the TTA nurse did not monitor the patient's pain level for changes.

Nursing Documentation

Documentation in health care is important because it serves as a permanent record of a patient's health information, treatment plans, and progress. It also helps ensure continuity of care and facilitates communication between health care providers, supports legal and regulatory requirements, and can help facilitate quality improvement efforts. Proper documentation also helps reduce errors and protects health care providers from potential legal liability.

Nurses did not always thoroughly document their patients' health care records. Nurses frequently did not document CPR and AED activities and at times, the time-line document was missing. Nurses did not always document communication as described in the following case example:

- In case 1, an LVN conducting COVID-19 isolations contacted the TTA RN regarding the patient's complaint of nausea. The TTA RN did not document communicating with the LVN and did not assess the patient. Moreover, on a separate occasion, a provider transferred the patient to the TTA for monitoring, but the TTA RN did not document communicating with the provider.

Emergency Medical Response Review Committee

The emergency medical response review committee (EMRRC) met regularly and discussed emergency events. However, we found that the EMRRC checklist was

frequently incomplete (MIT 15.003, 50.0%). We also found that the chief medical executive (CME) and chief nurse executive (CNE) did not perform clinical reviews on all the required events. In addition, when clinical reviews were conducted, these executives did not identify opportunities for improvement.[25] The following list provides examples:

- In case 5, health care staff initiated CPR, but delayed attaching an AED. CAC did not conduct a clinical review of this event and subsequently missed opportunities for improvement.

- In case 3, our clinicians identified several opportunities for improvement. One occurred when a nurse responded to a patient for whom custody was performing CPR. The nurse did not assess the patient for the presence of a carotid or femoral pulse. Instead, the nurse deviated from the standard of care and checked the patient's wrist for a pulse. In addition, the nurse did not apply an AED. These findings were not identified by CAC staff.

Clinician On-Site Inspection

At CAC, the TTA had two beds and was staffed with two RNs during each shift. During the on-site inspection, the OIG clinicians were informed by the CME that there was no dedicated TTA provider; however, there was a "doctor of the day." Nursing staff reported that this provider normally had the fewest number of patients scheduled to their provider line.

During our discussion, we learned that in August 2022, CAC began its emergency medical response (EMR) training. Nursing leadership indicated they used EMR audits as a method to assess the quality of care provided.

[25] In cases 1, 3, 4, and 6, CAC did not identify nursing deficiencies. CAC did not perform clinical reviews in cases 2 and 5.

Recommendations

- The department should consider the methods to ensure vital signs are monitored and automatically populated into patients' electronic health records.
- The institution should consider basic life support (BLS) remedial training and performance monitoring.

Health Information Management

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
***Proficient* (85.9%)**

Results Overview

In Cycle 6, CAC had good management of health information. Case review and compliance found that the institution usually retrieved and scanned hospital discharge reports on time. However, CAC had mixed performance in managing specialty and pathology reports. Moreover, compliance testing showed that CAC staff did not always properly scan, label, and include medical records in the correct patients' files. After reviewing all aspects, we rated this indicator ***adequate***.

Case Review and Compliance Results

The OIG clinicians reviewed 685 events and found 51 deficiencies related to health information management (HIM), four of which were significant.[26]

Hospital Discharge Reports

CAC performed well in retrieving community hospital discharge documents and scanning them into the electronic health record system (EHRS). Our clinicians reviewed 10 off-site emergency discharge department and hospital visits, and identified no deficiencies. Compliance testing found that staff timely retrieved hospital discharge records, scanned them into the EHRS, and reviewed them within required time frames (MIT 4.003, 100%). Staff also performed well in ensuring that hospital discharge records included a discharge summary (MIT 4.005, 87.5%).

Specialty Reports

CAC had a mixed performance in managing specialty reports. Case review clinicians identified deficiencies in late retrieval, scanning, and forwarding of specialty reports to the provider and a lack of timely provider report endorsements in six of 32 applicable cases.[27] Compliance testing showed

[26] Deficiencies occurred in cases 1, 5– 11, 13, 14, and 17–20. Cases 7, 14, and 20 had significant deficiencies.

[27] Specialty health information management deficiencies occurred in cases 7, 14, and 20. Significant deficiencies occurred in cases 7 and 20.

sufficient retrieval of specialty reports (MIT 4.002, 79.3%), but low rates of provider endorsement for all specialty reports: high-priority (MIT 14.002, 46.7%), medium-priority (MIT 14.005, 53.3%), and routine-priority (MIT 14.008, 42.9%).

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

Diagnostic Reports

Case review found that CAC generally performed well in retrieving and endorsing diagnostic reports timely. In contrast, staff did not retrieve pathology reports timely (MIT 2.010, 70.0%). Compliance testing showed that while providers reviewed pathology reports within specified time frames (MIT 2.011, 100%), providers performed poorly in timely communicating pathology results to patients (MIT 2.012, zero). Compliance did not have any STAT laboratory test samples to use in assessing timely provider acknowledgement or nursing notification of results to the provider (MIT 2.008, N/A).

Please refer to the **Diagnostic Services** indicator for further detailed discussion about diagnostics.

Urgent and Emergent Records

OIG clinicians reviewed 28 emergency care events and found that nurses did not always document these events well. The **Emergency Services** indicator provides additional details.

Scanning Performance

Compliance testing showed poor scanning, labeling, and filing performance (MIT 4.004, 62.5%). Our clinicians did not find any deficiencies involving mislabeled documents.

Clinician On-Site Inspection

We discussed health information management (HIM) processes with the HIM supervisor. The supervisor described the process of retrieving on-site and off-site reports, and routing them to providers for review. HIM staff utilized a "Special Tracking Report" that was maintained by the specialty nurse. Designated specialty office technicians tracked and retrieved specialty reports. HIM staff also received a record of appointments for a month at a time, and sometimes weekly. If the date for retrieving the report was nearing the compliance due date, staff would contact the specialty nurse for assistance in obtaining the reports. HIM staff also checked the TTA daily patient log to compare which patient went out for a specialty appointment or hospital visit to try to anticipate the need to obtain records. To track provider endorsement of records, the staff generated a weekly provider deficiency report that was sent to both the provider and the chief medical executive (CME).

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	23	6	16	79.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	16	0	0	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	15	9	0	62.5%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	14	2	0	87.5%
Overall percentage (MIT 4): **85.9%**				

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

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

Table 10. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	0	1	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	8	0	46.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	8	7	0	53.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	6	8	1	42.9%

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

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

Recommendations

- Medical leadership should determine the root cause of challenges in retrieving specialty consultations and pathology reports, and institute corrective action as needed.
- Medical leadership should ensure patients receive timely communication of pathology results.
- Medical leadership should determine the root cause of challenges to properly scan, label, and include medical records in the correct patients' files and institute corrective action as needed.

Health Care Environment

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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(31.1%)

Results Overview

In this cycle, multiple aspects of CAC's health care environment needed improvement: medical supplies' storage areas contained expired medical supplies; the emergency medical response bag (EMRB) logs inventory was not performed, or the bags were missing medical equipment; several clinics did not meet the requirements for essential core medical equipment and supplies; and staff did not regularly sanitize their hands before and after examining or performing invasive procedures on the patients. These factors resulted in an ***inadequate*** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

The institution had no outdoor waiting areas.

Indoor Waiting Areas

We inspected indoor waiting areas. Patients had enough seating capacity while waiting for their appointments. However, several patients choose to stand along the hallway while waiting for their appointments. We observed patients not wearing or not properly wearing their face coverings while in the waiting area (see Photo 1). We did not notice health care staff or custody staff educating patients regarding this matter.

Photo 1. Patients not wearing or not properly wearing their face coverings while in the clinic's waiting area (photographed on 7-14-22).

Clinic Environment

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

Of the eight clinics we observed, four contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 50.0%).

The remaining four clinics had one or more of the following deficiencies: the examination room lacked auditory privacy for conducting clinical examinations (see Photo 2, right), the examination table had a torn vinyl cover (see Photo 3, below), staff's personal items were stored with examination room supplies, or the examination room had unsecured confidential medical records.

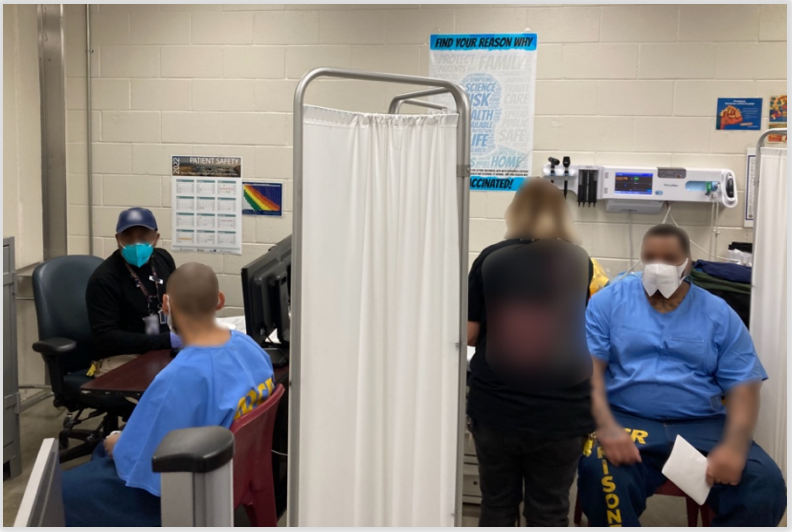

Photo 2. Clinical staff saw patients simultaneously in an examination room that prohibited auditory privacy (photographed on 7-13-22).

Photo 3. An examination table had a torn vinyl cover (photographed 7-13-22).

Clinic Supplies

None of the eight clinics followed adequate medical supply storage and management protocols (MIT 5.107, zero). We found one or more of the following deficiencies in all eight clinics: expired medical supplies (see Photo 4, below left, and Photo 5, below right).

Photo 4. Expired medical supply dated June 2019 (photographed on 7-13-22).

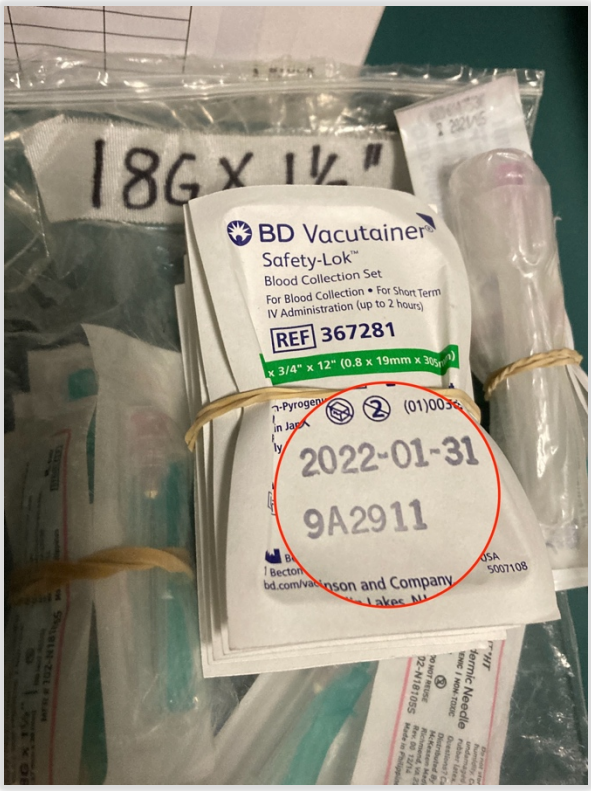

Photo 5. Expired medical supply dated January 31, 2022 (photographed on 7-14-22).

In addition, there were unidentified or inaccurately labeled medical supplies, cleaning materials stored with medical supplies, staff members' personal items and food stored with medical supplies (see Photos 6 and 7, below left and below right), medical supplies stored directly on the floor, and compromised sterile medical supply packaging.

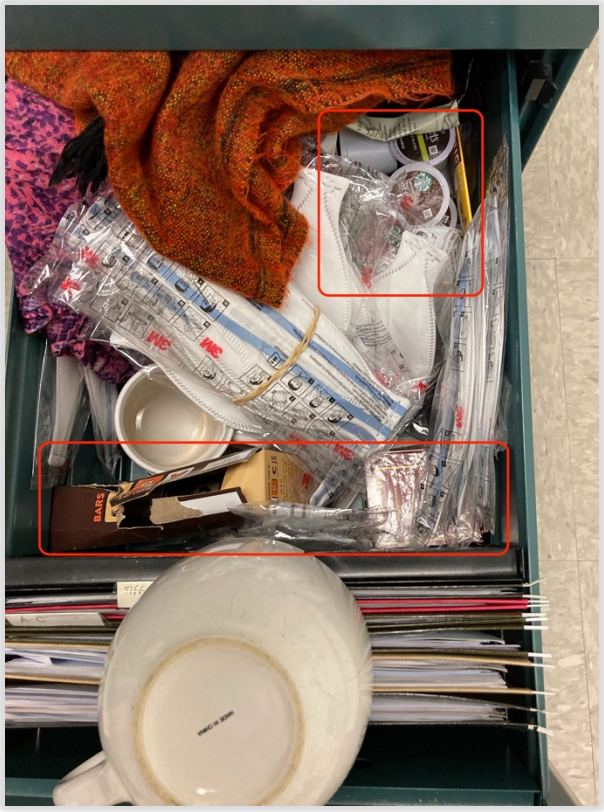

Photo 6. Staff members' personal items and food stored with medical supplies (photographed on 7-12-22).

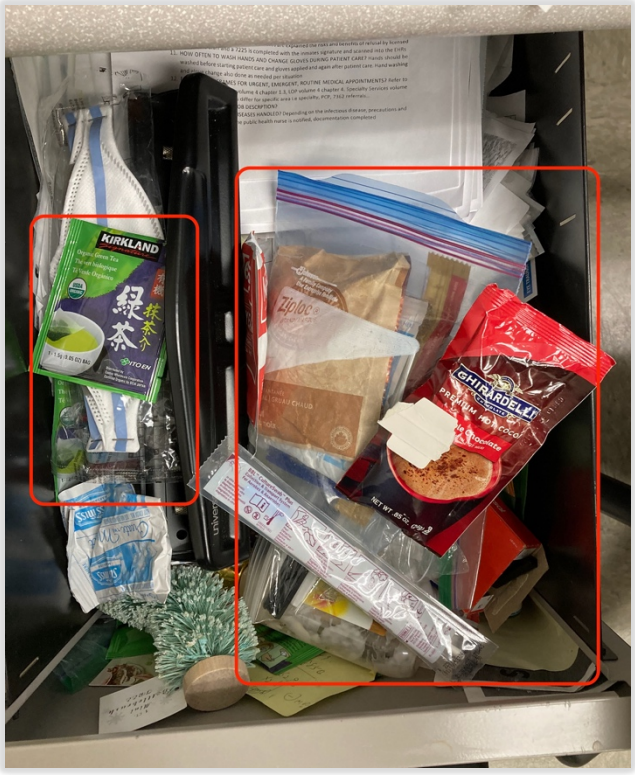

Photo 7. Staff members' personal items and food stored with medical supplies (photographed on 7-13-22).

Only one of the eight clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 12.5%). The remaining seven clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included a glucometer, peak flow meter, and nebulization unit. The staff had not properly calibrated several AEDs. The Snellen reading chart did not have a corresponding distance line marked on the floor or the wall, and there was also a nonfunctional oto-ophthalmoscope and expired lubricating jelly. TTA staff did not properly log the results of the defibrillator performance test within the last 30 days. Restrictive housing unit staff did not perform and log the glucometer quality control within the last 30 days.

We examined emergency medical response bags (EMRBs) to determine if they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. None of the five EMRBs passed our test (MIT 5.111, zero). We found one or more of the following deficiencies with all the EMRBs: staff had not inventoried the EMRBs when seal tags were replaced or had not inventoried the EMRBs in the previous 30 days; and several medical supplies were missing, or the original packaging was compromised at the time of our inspection. The TTA crash cart did not meet the minimum inventory level, and it was documented that reasonable substitutions were made. In addition, we found expired medical supplies stored in the TTA crash cart.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics contained medical supplies stored adequately (MIT 5.106, zero). We found expired medical supplies (see Photo 8, right, and Photo 9, next page).

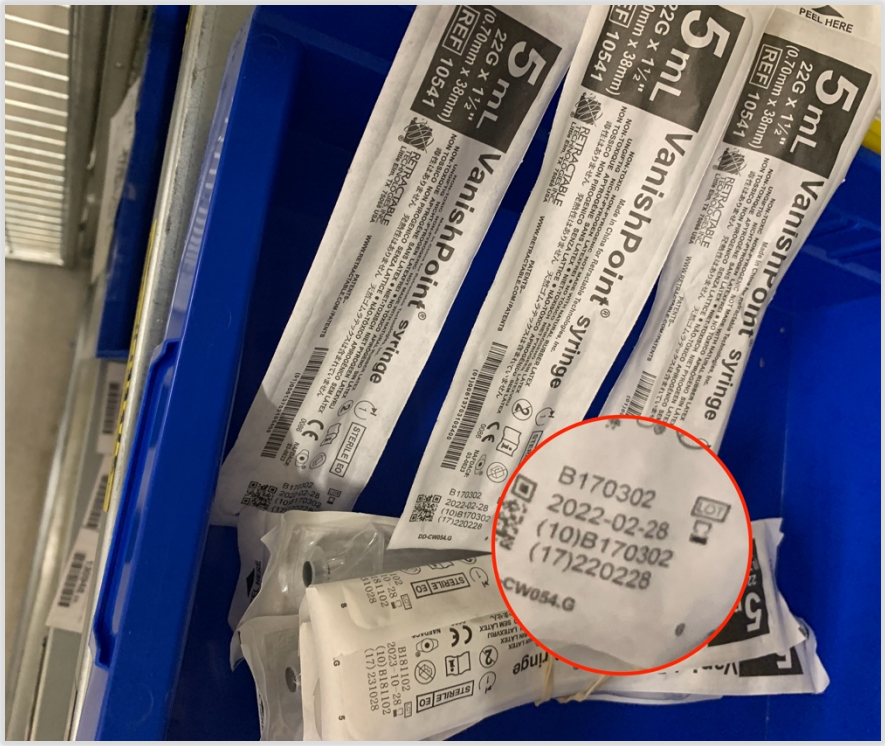

Photo 8. Expired medical supplies dated February 28, 2022 (photographed 7-13-22).

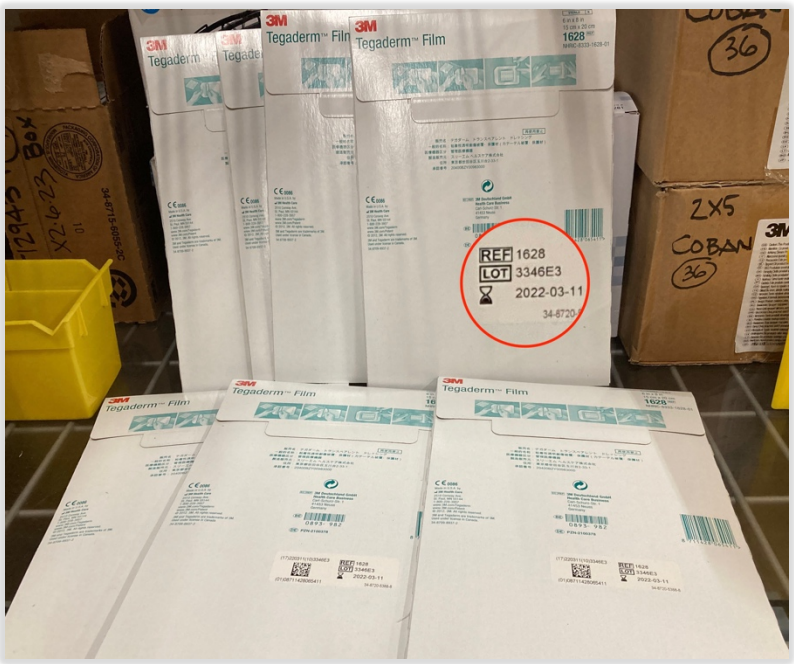

Photo 9. Expired medical supplies dated March 11, 2022 (photographed 7-13-22).

According to the CEO, the institution did not have any concerns about the medical supplies process. Health care managers and medical warehouse managers expressed no concerns about the medical supply chain or with their communication processes.

Photo 10. At the time of our inspection, the clinic floor was unsanitary; and there was a dead insect (photographed on 7-14-22).

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected five of eight clinics (MIT 5.101, 62.5%). In three clinics, we found one or more of the following deficiencies: cleaning logs were not maintained, one clinic floor had a dead insect (see Photo 10), and accumulated dust on the clinic floor and under the clinic sink was in evidence.

None of the eight clinics properly sterilized or disinfected medical equipment (MIT 5.102, zero). For all clinics, staff did not mention disinfecting the examination table as part of their daily start-up protocol. In one of the eight clinics, staff did not initial the packaging of sterilized medical equipment, and we found previously sterilized medical equipment packaging compromised.

We found operating sinks and hand hygiene supplies in the examination rooms in seven of eight clinics (MIT 5.103, 87.5%). The patient restroom in one clinic lacked antiseptic soap and disposable hand towels.

We observed patient encounters in six clinics. In five clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, or after performing blood draws (MIT 5.104, 16.7%).

Health care staff in only one of eight clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 12.5%). In seven clinics, staff did not demonstrate an understanding of when disinfection is necessary.

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order (MIT 5.999).

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	5	3	0	62.5%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	0	8	0	0
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	7	1	0	87.5%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	1	5	2	16.7%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	1	7	0	12.5%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	0	8	0	0
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	1	7	0	12.5%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	8	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	4	4	0	50.0%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	0	5	3	0
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 5): **31.1%**			

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

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

Recommendations

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

Transfers

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (74.9%)**

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

Results Overview

CAC performed sufficiently in this indicator. Compared with Cycle 5, CAC's compliance score declined by more than 10 percentage points, from 85.2 percent to 74.9 percent. In Cycle 6, nurses showed improvement in the assessment and disposition sections for newly arriving patients; however, nurses' assessments often missed items, or the items were completed after patients left the receiving and release area (R&R). CAC also improved in ensuring medication continuity for newly arrived patients, although at times, transfer packets were incomplete. Patients returning from a community hospital were promptly evaluated by their provider. Taking all things into consideration, we rated this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 43 events in 16 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 10 deficiencies, one of which was significant.[28]

Transfers In

We found CAC's transfer-in process was sufficient, but showed opportunities for improvement. OIG clinicians reviewed 14 events in five cases in which patients transferred into the facility from other institutions. We identified three deficiencies, one of which was significant which is described below:[29]

[28] Deficiencies occurred in cases 1, 6, 14, 21, and 23–25. Case 21 had a significant deficiency.

[29] Deficiencies occurred in cases 6, 21, and 23. Case 21 had a significant deficiency.

- In case 21, the patent had a history of latent TB, heart valve replacement, and was prescribed chronic care medications. The transfer nurse did not initiate a seven-day provider appointment and did not arrange a follow-up appointment for the patient's diagnosis of latent TB.[30]

Compliance testing found that nurses always completed the assessment and disposition sections of the initial assessment sections (MIT 6.002, 100%). However, compliance and our case review found that nurses' initial health screenings had missing information or that the screenings were not completed within the required time frame (MIT 6.001, 56.0%). We also identified that newly arriving patients were not always evaluated timely by their care team (MIT 1.002, 50.0%). In addition, compliance tests showed performance in medication continuity was fair (MIT 6.003, 76.9%).

Our compliance tests also showed that patients who transferred into CAC with preapproved specialty referrals were not frequently evaluated within required time frames (MIT 14.010, 42.9%). OIG clinicians did not have any cases to review with preapproved specialty referrals.

Transfers Out

We found CAC's transfer-out process was satisfactory. OIG clinicians reviewed three transfer-out cases and found three deficiencies.[31] On two occasions, the nurse did not document the patient's pending specialist appointments and in one other transferring patient, the nurse did not record whether the patient had their rescue inhaler on their person.

Compliance testing found that patients who transferred out of the institution did not always have their prescribed medications (MIT 6.101, 66.7%). For one patient, the transfer packet did not have the required medication.

Hospitalizations

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

CAC performed well in retrieving and reviewing hospital records (MITs 4.003, 100%, and 4.005, 87.5%). Our clinicians reviewed 10 hospital or emergency room returns and found four deficiencies, none of which were significant.[32]

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[30] KOP means keep on person and refers to medications in which a patient can keep and self-administer according to the directions provided.

[31] Deficiencies occurred in case 25 and twice in case 24.

[32] Deficiencies occurred in cases 1, 6, and 14.

Both compliance and case review teams found CAC's performance was very good in providing follow-up appointments within required time frames for patients returning from the hospital and emergency room (MIT 1.007, 93.3%).

Our clinicians and compliance teams found opportunities for improvement in CAC staff ensuring medication continuity (MIT 7.003, 71.4%). Case review identified three deficiencies related to medication continuity; an example follows:[33]

- In case 1, a maintenance inhaler (Dulera) was ordered to start on the day the patient returned from the hospital, but was provided to the patient one day late.

Clinician On-Site Inspection

During our on-site visit, we learned that the R&R area was staffed with RNs on each shift. The R&R nurses evaluated newly arriving and departing patients. The TTA was staffed with two RNs each shift, and the RNs evaluated patients returning from community hospitals.

Nursing leadership indicated their staff used the OIG audits and CAC's quality dashboard data to ensure nurses provide quality care to their patients. Nursing leadership also indicated that concerns relating to patient transfers were shared and addressed during huddles.

[33] Deficiencies occurred in cases 1, 6, and 14.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	14	11	0	56.0%
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	25	0	0	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	10	3	12	76.9%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	2	1	0	66.7%
				Overall percentage (MIT 6): **74.9%**

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

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

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	12	12	1	50.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	14	1	1	93.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	16	0	0	100%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	14	2	0	87.5%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	10	4	2	71.4%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	21	4	0	84.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	5	1	0	83.3%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	3	4	0	42.9%

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

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

Recommendations

- Health care leadership should identify the challenges to medication continuity for patients returning from hospitalizations or emergency rooms; leadership should implement remedial measures as appropriate.
- Nursing leadership should educate nursing staff on the requirements for documenting an initial health screening.
- Medical leadership should ensure that patients receive their previously scheduled specialty appointments, when transferred, within the required time frame.

Medication Management

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

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (49.7%)**

Results Overview

CAC had a mixed performance in this indicator. CAC performed poorly in compliance testing and in medication related practices and controls. Compared with Cycle 5, CAC's compliance score fell dramatically, declining nearly 38 percentage points. In Cycle 5, CAC scored 87.2 percent; however, in this cycle, the score was 49.7 percent. Although the case review team rated this indicator ***adequate***, when we compared the Cycle 5 and Cycle 6 compliance results, this steep decline in performance contributed to an overall rating of ***inadequate***.

Case Review and Compliance Testing Results

The case review team reviewed 98 events in 27 cases related to medications and found six medication deficiencies, one of which was significant.[34]

New Medication Prescriptions

Compliance testing found that 84.0 percent of new medications were available or administered timely (MIT 7.002). Our clinicians found four deficiencies, an example of which is listed below:[35]

- In case 8, a new dose of a diabetic medication was not issued to the patient.

Chronic Medication Continuity

Compliance testing showed that patients frequently did not receive their medications the day before exhaustion as required by policy (MIT 7.001, 16.7%). Our clinicians found three deficiencies related to continuity of chronic care medications.[36]

[34] Deficiencies occurred in cases 1, 2, 8, 13, and 14. A significant deficiency occurred in case 8.

[35] Deficiencies occurred in cases 1, 2, 8, and 13.

[36] Deficiencies occurred in cases 1, 13, and 14.

Hospital Discharge Medications

Our clinicians found that CAC staff performed well in ensuring patients received their medications after a community hospital visit. Compliance results showed that MIT 7.003 had a low score of 71.4 percent in part because KOP medications which were prescribed and ordered to start the same day had delays.

Transfer Medications

Compliance results showed that patients transferring within CAC housing units were usually offered their medications (MIT 7.005, 84.0%). However, nurses did not always document the reason for medication refusals.

Our clinicians found that CAC performed well in ensuring medication continuity of newly arriving and departing patients. Compliance testing scored 76.9 percent for medication continuity for newly arrived patients who were prescribed KOP medications (MIT 6.003). However, with a lower score of 66.7 percent, compliance testing showed that departing patients' transfer packets did not always contain all required medications (MIT 6.101).

Medication Administration

CAC staff performed very well in ensuring TB medications were administered timely (MIT 9.001, 100%). However, compliance testing showed that nurses did not always thoroughly monitor patients with prescribed TB medications (MIT 9.002, 33.3%). In contrast, in Cycle 5, CAC had a score of 75.0% for this MIT.

Clinician On-Site Inspection

During the on-site visit, OIG clinicians met with the pharmacist and toured the pill lines. During our discussion, the pharmacist informed us that at CAC, certain medications like eye drops, creams, and inhalers are not issued monthly. Instead, patients request refills of nonscheduled, KOP medications by submitting a refill request through the CDCR 7362 sick call process. However, if the medication is "scheduled," it will automatically be dispensed to the pill line for the patient to pick up. In addition, the pharmacist also indicated that the primary care team frequently discusses patients' medication compliance and renewals.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in six of seven clinic and medication line locations (MIT 7.101, 85.7%). In one location, narcotic medications were not properly securely stored as required by CCHCS policy.

CAC staff appropriately stored and secured nonnarcotic medications in three of eight clinic and medication line locations (MIT 7.102, 37.5%). In five locations, we

observed one or more of the following deficiencies: the medication storage cabinet was disorganized; there were no identifiable designated areas for refrigerated medications or medications with expired pharmacy labels that were to be returned to the pharmacy; and the TTA crash cart log was missing several daily security-check entries.

Staff did not keep medications protected from physical, chemical, and temperature contamination in any of eight clinic and medication line locations (MIT 7.103, zero). In all eight locations, we found one or more of the following deficiencies: staff did not consistently record room and refrigerator temperatures; staff did not store oral and topical medications separately; staff did not separate medications from personal food items; and the medication refrigerator was unsanitary.

Staff successfully stored valid and unexpired medications in three of the eight applicable medication line locations (MIT 7.104, 37.5%). In five locations, we found one or both of the following deficiencies: medication nurses did not label multiple-use medication as required by CCHCS policy or there were expired medications.

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

In four of six medication preparation and administration areas, staff demonstrated appropriate administrative controls and protocols (MIT 7.106, 66.7%). In two locations, nurses did not maintain unissued medication in its original labeled packaging.

Staff in one of six medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 16.7%). In five locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within the time frame of one hour before or one hour after the normal distribution time; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; medication nurses did not consistently verify patients' identifications by using a picture form of identification prior to administering medications; nurses could not describe the medication error reporting process; medication nurses did not follow the CCHCS care guide when administering Suboxone medication; and nurses did not follow insulin protocols properly. During insulin administration, we observed some medication nurses did not properly disinfect the insulin vial prior to withdrawing medication or disinfecting the glucometer after each patient use. In addition, a medication nurse applied an unlabeled sticker without a beyond-use date over the previously opened multiple-dose insulin's expiration date.

Pharmacy Protocols

CAC followed general security, organization, and cleanliness management protocols in its pharmacy (MIT 7.108, 100%).

In its pharmacy, staff did not properly store nonrefrigerated medication. We found expired and unorganized medications. As a result, the institution scored zero in this test (MIT 7.109).

The institution did not properly store refrigerated or frozen medications in the pharmacy. We found an unsanitary refrigerator. As a result, the institution scored zero in this test (MIT 7.110).

The pharmacist-in-charge (PIC) correctly accounted for narcotic medications stored in CAC's pharmacy (MIT 7.111, 100%).

We examined 11 medication error reports. The PIC timely or correctly processed only five of these 11 reports (MIT 7.112, 45.5%). In five reports, the PIC did not document the following: an explanation for not notifying the provider or the patient; the PIC's determinations or findings of the error; or the PIC's name. For the remaining report, the PIC did not complete the pharmacy error follow-up review within the required time frame.

Nonscored Tests

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

The OIG interviewed patients in isolation units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. The two patients interviewed indicated they had access to their rescue medications (MIT 7.999).

Compliance Testing Results

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	3	15	7	16.7%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	21	4	0	84.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	10	4	2	71.4%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	21	4	0	84.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	5	1	0	83.3%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	6	1	3	85.7%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	3	5	2	37.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	0	8	2	0
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	3	5	2	37.5%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	1	5	4	16.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	4	2	4	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	1	5	4	16.7%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	5	6	0	45.5%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **49.7%**

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

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

Table 15. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	10	3	12	76.9%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	2	1	0	66.7%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	21	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	7	14	0	33.3%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	N/A	N/A	N/A	N/A

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

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

Recommendations

- Medical and nursing leadership should ensure that chronic care, hospital discharge, and en-route patients receive their medications timely and without interruption; leadership should implement remedial measures as appropriate.

- Nursing leadership should consider reminding nursing staff to document patient refusals in medical administration records, as described in CCHCS policy and procedures.

Preventive Services

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

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(75.6%)

Results Overview

CAC performed adequately in administering TB medications to patients, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. However, CAC staff faltered in monitoring patients taking prescribed TB medications, screening patients annually for TB, and offering required immunizations to chronic care patients. Overall, we rated this indicator ***adequate***.

Compliance Testing Results

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	21	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	7	14	0	33.3%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	18	7	0	72.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	24	1	0	96.0%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	23	2	0	92.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	9	6	10	60.0%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
Overall percentage (MIT 9): **75.6%**				

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

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

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

Recommendations

- Nursing leadership and the public health nurse should educate nursing staff on properly documenting TB signs and symptoms when monitoring patients who are taking TB medications.

Nursing Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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

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

Results Overview

CAC nurses generally delivered good care. Nurses provided timely face-to-face appointments, and most nurses performed appropriate assessments and interventions for patients submitting sick calls or returning from the hospital. In this cycle, we are most concerned with the emergency nursing care provided by first medical responders and TTA nurses. Nursing supervisors and leadership conducting clinical reviews did not identify the opportunities for improvement in their clinical reviews. After considering all factors, we rated this indicator ***adequate.***

Case Review Results

We reviewed 179 nursing encounters in 34 cases. Of the nursing encounters we reviewed, 117 were in the outpatient setting. We identified 54 nursing performance deficiencies, 11 of which were significant.[37]

Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements. Nurses generally provided appropriate nursing assessments and interventions in the outpatient setting; however, we identified opportunities for improvement. The following are examples:

[37] Deficiencies occurred in cases 1–8, 10, 11, 14, 16, 17, 19, 21, 23–25, 27, 28, 32, and 35. Cases 1, 3, 4, 5, 19, and 21 each had a significant deficiency.

- In cases 1 and 14, nurses evaluated the COVID-19 isolated patients, but did not provide sufficient assessments of their abnormal clinical findings.

- In case 19, the patient complained to the nurse of difficulty swallowing and jaw pains. The nurse did not assess the frequency of the patient's symptoms, did not obtain the patient's vital signs, and did not consult a provider regarding these complaints.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. CAC staff generally documented care appropriately. However, emergency services and transfers showed room for improvement, which we discuss in the **Emergency Services** and **Transfers** indicators.

Nursing Sick Call

Our clinicians reviewed 17 sick call requests. Nurses provided timely face-to-face appointments, and most nurses performed appropriate assessments and interventions. However, the following are examples of deficiencies we identified:

- In case 11, the patient submitted a sick call request for chest pain. The sick call nurse evaluated the patient promptly, but did not perform a thorough subjective assessment.

- In case 35, the patient complained of urinary symptoms. The sick call nurse did not assess when the patient's symptoms began and did not perform a urine dipstick test to assess the patient's urine for abnormalities.[38]

Wound Care

We reviewed four cases in which patients had wounds.[39] In two of the four cases, the patients provided their own wound care. In one case, we cited a deficiency because a provider mistakenly did not initiate wound care orders.[40] In the other case, nurses provided sufficient wound care.

Emergency Services

We reviewed 17 urgent or emergent events. Nurses responded promptly to emergent events. However, we identified that nurses did not perform sufficient

[38] A urine dipstick test is a clinic urine test performed at the time of clinic appointment to quickly determine if the patient's urine show signs of infection.

[39] In cases 12, 14, 19, and 20, patients had wounds requiring wound care.

[40] This deficiency occurred in case 20.

emergency care for one patient who required BLS CPR. In addition, nurses did not always assess and monitor their patients closely when necessary. Please see the **Emergency Services** indicator for additional details.

Hospital Returns

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

Transfers

We reviewed eight cases involving transfer-in and transfer-out processes and identified six deficiencies. Although opportunities for improvement were identified, most nursing deficiencies were related to nurses' incomplete documentation. One significant deficiency occurred and is discussed in this indicator. Please refer to the **Transfers** indicator for further details.

Specialty Services

We reviewed 21 events in which patients returned after an off-site specialist appointment and identified six deficiencies. Although none of the six deficiencies were significant, they included opportunities for nurses to improve their assessments, interventions, and documentation. Please refer to the **Specialty Services** indictor for additional details.

Medication Management

OIG clinicians examined 98 events in 27 cases involving medication management and found nine deficiencies. We identified that nurses documented patients did not receive prescribed medications because the patients had not requested refills. However, the medications did not require the patients to request refills and should have been offered to the patients. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

At the on-site visit, our clinicians interviewed nurses in TTA, specialty, and in the clinics. Huddles in the clinics were held via videoconference and were attended by the providers, RNs, LVNs, utilization management nurse (UM), office assistant, mental health, and quality management team. Staff indicated they had no back log for RN and LVN appointments.

We met with the acting CNE and the acting director of nursing (DON) who addressed our findings and acknowledged several opportunities for improvements in nursing documentation and assessment.

Recommendations

The OIG offers no recommendations for this indicator.

Provider Performance

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score **(N/A)**

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

Results Overview

CAC providers delivered good care as they did in Cycle 5. Providers generally ordered appropriate follow-up and specialty referrals in addition to making proper assessments. They referred patients to a higher level of care when necessary and managed chronic medical conditions effectively. There was a pattern of incomplete patient examinations and documentation errors, but these deficiencies were not significant. Overall, we rated this indicator ***adequate***.

Case Review Results

The OIG clinicians reviewed 71 medical provider encounters and identified 38 deficiencies related to provider performance, none of which were significant.[41] In addition, our clinicians examined the quality of care in 18 comprehensive case reviews.

Assessment and Decision-Making

Providers generally made appropriate assessments and sound decisions for their patients. Most of the time, they took good histories, ordered appropriate tests, made the correct diagnoses, and referred patients to proper specialists when needed. However, providers did not always examine patients according to their medical complaints and sometimes ignored their medical conditions. We identified these problems in 22 unique occurrences in 10 of the 18 detailed cases we reviewed.[42] This demonstrated a pattern, and the following are examples:

- In case 5, the provider saw the patient for a chronic care appointment and did not document the patient's obesity and did not discuss lifestyle changes with the patient.
- In case 6, the nurse sent a message to the provider regarding the patient's complaint of severe left ankle pain after walking or running for an hour; however, the provider did not order a follow-up provider

[41] Deficiencies occurred in cases 1, 2, 5–13, and 16–21. There were no significant deficiencies.

[42] Providers did not examine patients appropriately in cases 1, 2, 5–8, 10, 17, 19, and 21.

appointment to reassess the change in the patient's chronic left ankle pain.

- In case 17, the provider saw the patient for a hospitalization return follow-up and did not perform a review of systems or ask the patient for any other subjective information or symptoms; in addition, the provider did not address the patient's elevated blood pressure.

Review of Records

Generally, providers reviewed medical records carefully. We found some deficiencies related to vital signs reviews and specialty follow-ups, none of which were considered significant.[43] The following are examples:

- In case 7, the provider canceled a chronic care visit in lieu of a chart review and reviewed the patient's history of diabetes; however, the provider did not review the patient's history of hypertension and did not identify that the last recorded blood pressure reading was abnormal.

- In case 8, the provider saw the patient for a chronic care visit to follow up on the patient's uncontrolled diabetes; however, the provider did not review the patient's vital signs.

- In case 18, the provider conducted a chart review instead of seeing the patient for a specialty follow-up visit because the patient was in COVID-19 quarantine; however, the provider did not thoroughly review the consultation report and did not order a multivitamin as recommended by the specialist.

Emergency Care

Providers made appropriate triage decisions when patients arrived at the TTA for emergency treatment. In addition, providers were available for consultation with TTA staff. We identified three deficiencies related to emergency care, none of which were considered significant:

- In case 1, the TTA nurse notified the provider about the patient's vital signs and cardiac rhythm strip, but the provider did not document a progress note.[44]

- In case 2, the provider evaluated the patient in the TTA and did not review the patient's vital signs.

- In case 17, the provider co-consulted with a nurse on the patient presenting to the TTA for left-side groin pain. The provider

[43] Deficiencies occurred in cases 7, 8, 12, 16 and 18. There were no significant deficiencies.

[44] A cardiac rhythm strip is a tracing of at least six seconds that is printed out on graph paper, which shows the electrical activity of the heart.

documented right-side groin pain as the assessment, but did not perform a right-side groin examination; in addition, the provider did not accurately document the result of the urine dipstick test.

Chronic Care

In most instances, providers appropriately managed patients' chronic health conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. We identified only two deficiencies, neither of which were considered significant.[45]

Specialty Services

Providers appropriately referred patients for specialty consultation when needed. When specialists made recommendations, the providers followed these recommendations appropriately and reviewed specialty reports timely. We discuss providers' specialty performance further in the **Specialty Services** indicator.

Documentation Quality

Providers accurately documented encounters with patients and communication with nurses. Our clinicians identified nine deficiencies, none of which were significant.[46]

Patient Notification Letter

Providers did not always send patient notification letters to patients. When they did, the letters did not always contain the four elements required by policy. This is discussed separately in the **Health Information Services** indicator.

Provider Continuity

Provider continuity was generally good, with most providers attending to patients on one yard for long periods of time, and in some cases, for years. We did not find any deficiencies related to provider continuity.

Clinician On-Site Inspection

We interviewed medical leadership and providers. Medical leadership reported having no formal vacancies at the time of the on-site inspection despite being down two providers. One provider was out on medical leave and one retired annuitant had completed his assignment in September 2022, increasing the workload of the remaining providers. Providers sometimes saw patients by telemedicine and worked from home. If the teleworking provider needed a

[45] Deficiencies occurred in cases 1 and 13.

[46] Deficiencies occurred in cases 1, 8, 11, and 17.

procedure to be completed for the patient, that provider would consult an on-site provider. Medical staff also reported that most providers called in to huddles on their days off and were also readily accessible during work hours.

Providers stated that CAC had a centrally located medical clinic, which allowed providers to work close together. Providers cited this behavior as fostering comradery and the ability to consult one another as needed. Providers generally reported good morale and that the CME and the acting chief physician and surgeon (CP&S) were readily available and supportive. One provider stated that the CME regularly reviewed charts and at times, provided medical intervention as clinically indicated. In addition, the CME mentioned about completing regular OPPE (ongoing professional practice evaluation) of providers.

Recommendations

- Medical leadership should ensure that providers include subjective and objective patient care data in all patient encounters as per policy.

Specialty Services

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

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (66.5%)**

Results Overview

CAC's Cycle 6 performance was mixed for specialty services. Case review found that the institution completed specialty referrals and that the providers reviewed specialty reports timely. Similarly, compliance testing determined that the institution completed medium-priority and routine-priority specialty appointments within required time frames. However, the compliance testing found that the institution had difficulties with timely initial high-priority specialty and provider follow-up appointment completion. In addition, compliance testing ascertained that CAC struggled with timely specialty report retrieval and provider review. Considering compliance and case reviews together, on balance, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 72 events related to this indicator, which included 32 specialty consultations, 10 specialty procedures, and 21 nursing encounters. There were 13 deficiencies, three of which were considered significant.[47]

Access to Specialty Services

CAC's performance in this area was mixed. Compliance testing showed that the institution provided medium-priority and routine-priority specialty appointments timely (MIT 14.004, 100% and MIT 14.007, 86.7%). However, CAC did not provide high-priority appointments and transfer continuity of specialty services within required time frames (MIT 14.001, 53.3% and MIT 14.010, 42.9%). Case review found one deficiency in specialty appointment completion, which was not considered significant.[48]

Provider Performance

Providers delivered a mixed performance. Compliance testing determined that providers did not always see patients promptly after completion of specialty services (MIT 1.008, 73.2%). In contrast, OIG clinicians determined that providers generally ordered appropriate specialty consultations and that these

[47] Deficiencies occurred in cases 7, 14, 19, and 20. Two significant deficiencies occurred in case 7, and one significant deficiency occurred in case 20.

[48] A deficiency occurred in case 7.

consultations were completed in the proper time frames. Case review also found that provider follow-up appointments after specialty consultations were completed timely. OIG clinicians identified only one deficiency in which the provider did not properly review a specialty report.

Nursing Performance

Nurses performed adequately in assessing patients who returned to the facility from off-site appointments. Clinicians reviewed 21 nursing encounters and identified six deficiencies.[49] This is discussed further in the **Nursing Performance** indicator.

Health Information Management

CAC staff managed health information with variable results. Compliance testing showed that specialty report retrieval and provider review was poor for high-priority, medium-priority, and routine-priority specialty reports (MIT 14.002, 46.7%, MIT 14.005, 53.3%, and MIT 14.008, 42.9%). However, compliance testing showed that CAC scanned specialty reports within the required time frame (MIT 4.002, 79.3%). The case review team found that staff, in general, timely retrieved and scanned specialty reports, as well as forwarded the specialty reports to the provider for review. Our clinicians identified five deficiencies related to delay in retrieving and scanning specialty reports within the required time frame.[50] Of the five deficiencies, we identified the three cases as having significant deficiencies, two of which are described below:

- In case 7, a hematology physician order page was scanned into the patient's electronic health record, but was not forwarded to the provider for review. In addition, the patient saw a telemedicine endocrinology specialist, but the specialty report was not scanned until seven days later.

- In case 20, an off-site orthopedic surgeon saw the patient for follow-up, and the orthopedic specialty report was scanned into the electronic health record more than five days later.

Clinician On-Site Inspection

We discussed specialty-related processes with HIM supervisors, office technicians, ancillary and diagnostic staff, nurses, and providers. Specialty nursing reported that CAC had lost some specialists earlier in 2022, affecting access to specialty care. Off-site orthopedics surgery, general surgery, and pulmonary specialists were more difficult to obtain, while the cardiology

[49] Deficiencies occurred in cases 7, 14, and 19.

[50] Deficiencies occurred in cases 7, 14, and 20. Two significant deficiencies occurred in case 7 and one significant deficiency occurred in case 20.

specialty was more accessible. Staff reported that telemedicine specialty access has varied. Access improved after the middle of the year.

Compliance Testing Results

Table 17. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	8	7	0	53.3%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	1	6	88.9%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	15	0	0	100%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	2	7	75.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	6	8	1	42.9%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	3	1	11	75.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	3	4	0	42.9%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	N/A	N/A	N/A	N/A
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 14): **66.5%**

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

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

Table 18. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	30	11	4	73.2%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	23	6	16	79.3%

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

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

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges to the timely provision of specialty appointments and should implement remedial measures as appropriate.

- Medical leadership should ascertain the challenges in the timely receipt, and the provider review, of specialty reports, and implement remedial measures as appropriate.

Administrative Operations

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(77.4%)

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

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

Results Overview

CAC's performance was mixed in this indicator, as the institution scored well in some applicable tests, but faltered in others. The Emergency Medical Response Review Committee (EMRRC) did not always complete the required checklists. In addition, the institution conducted medical emergency response drills with incomplete documentation. Nurse managers did not always complete timely annual competency reviews of nurses who administer medications. Last, nursing managers did not ensure newly hired nurses received the required onboarding training. These findings are set forth in the table on the next page. Overall, we rated this indicator ***adequate***.

Nonscored Results

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

The institution reported only one death during our review period. The OIG did not have sufficient samples to be tested; therefore, we exempted this test (MIT 15.998) from our compliance review process.

Compliance Testing Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) *	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	6	6	0	50.0%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	1	2	0	33.3%
Did the responses to medical grievances address all of the inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	1	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	7	3	0	70.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	3	1	0	75.0%
Did the providers maintain valid state medical licenses? (15.106)	6	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **77.4%**			

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

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

Recommendations

The OIG offers no recommendations for this indicator.

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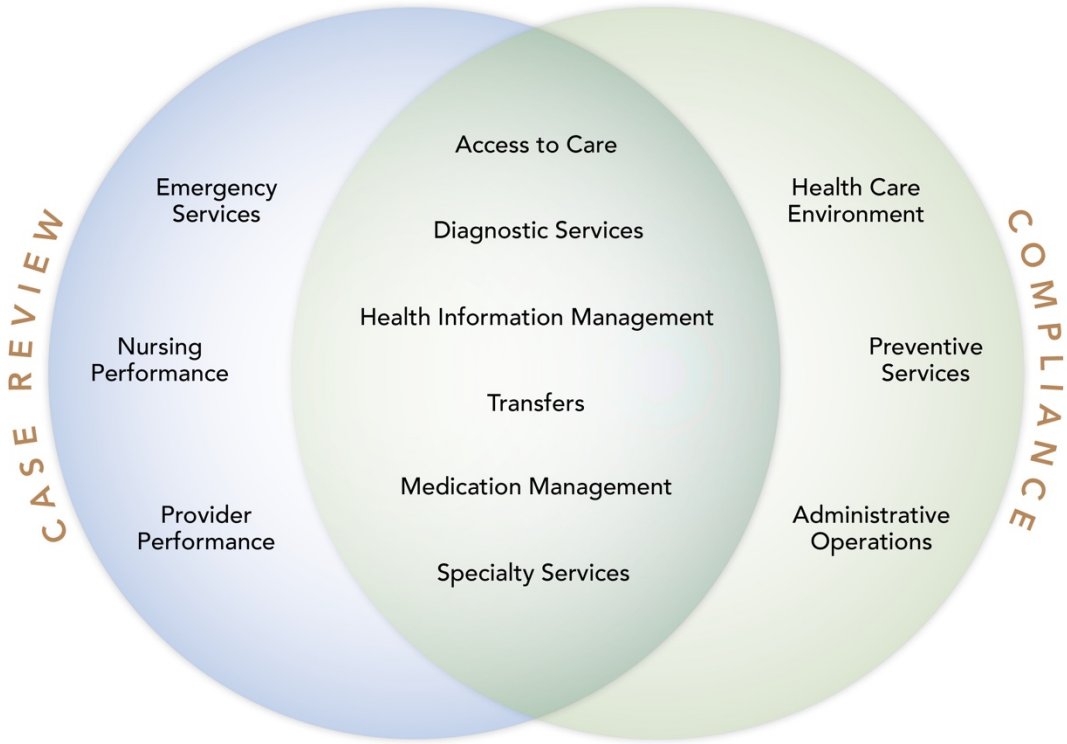
Appendix A: Methodology

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

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

Figure A–1. Inspection Indicator Review Distribution for CAC



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

Case Reviews

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

Table A–1. Case Review Definitions

Case, Sample, or Patient	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
Comprehensive Case Review	A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.
Focused Case Review	A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.
Event	A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.
Case Review Deficiency	A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy noncompliance, elevated risk of patient harm, or both.
Adverse Event	An event that caused harm to the patient.

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

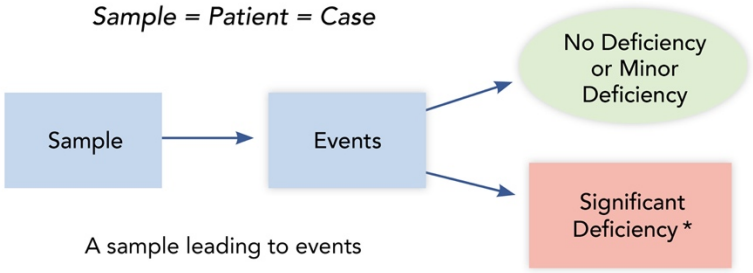
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an ***adverse event***. On the next page, Figure A–2 depicts the possibilities that can lead to these different events.

After the clinician inspectors review all the cases, they analyze the deficiencies, then summarize their findings in one or more of the health care indicators in this report.

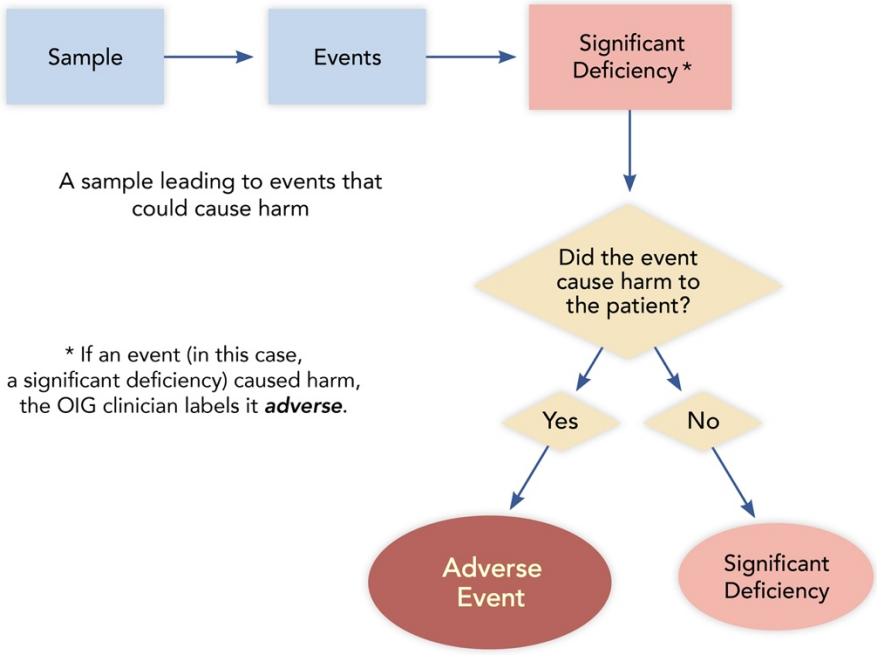
Figure A–2. Case Review Testing

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



Deficiencies

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



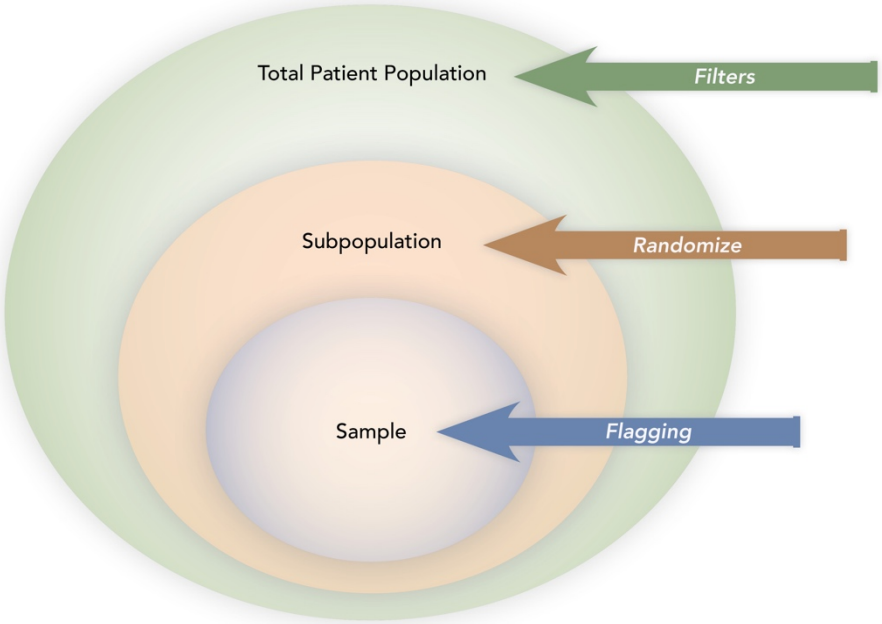
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A–3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

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

Indicator Ratings and the Overall Medical Quality Rating

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

Appendix B: Case Review Data

Table B–1. CAC Case Review Sample Sets

Sample Set	Total
Anticoagulation	1
Death Review / Sentinel Events	1
Diabetes	4
Emergency Services – CPR	2
Emergency Services – Non-CPR	2
High Risk	3
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	9
Specialty Services	3
	35

Table B–2. CAC Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Anticoagulation	1
Arthritis/Degenerative Joint Disease	1
Asthma	6
Chronic Pain	5
Cirrhosis/End-Stage Liver Disease	1
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	6
Gastroesophageal Reflux Disease	2
Hepatitis C	9
Hyperlipidemia	7
Hypertension	6
Mental Health	1
Sleep Apnea	1
Substance Abuse	11
Thyroid Disease	1
	62

Table B–3. CAC Case Review Events by Program

Diagnosis	Total
Diagnostic Services	219
Emergency Care	30
Hospitalization	18
Intra-system Transfers In	14
Intra-system Transfers Out	11
Outpatient Care	320
Specialty Services	73
	685

Table B–4. CAC Case Review Sample Summary

	Total
MD Reviews Detailed	18
MD Reviews Focused	2
RN Reviews Detailed	10
RN Reviews Focused	22
Total Reviews	52
Total Unique Cases	35
Overlapping Reviews (MD & RN)	17

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Appendix C: Compliance Sampling Methodology

California City Correctional Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	16	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 Ips for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 Ips for each question
MIT 4.003	Hospital Discharge Documents	16	OIG Q: 4.005	• Community hospital discharge documents • First 20 Ips selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	16	CADDIS Off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	8	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	3	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of Ips tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	16	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	6	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	11	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	2	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for Ips housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	21	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out Ips tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. Prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. Prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	0	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

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

MIT 14.010	Specialty Services Arrivals	7	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	0	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events (ASE)	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	N/A at this institution	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	1	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	4	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	6	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications

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

California Correctional Health Care Services' Response

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June 22, 2023

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

Dear Ms. Singh:

The Office of the Receiver has reviewed the draft Medical Inspection Report for California City Correctional Facility (CAC) conducted by the Office of the Inspector General (OIG) from November 2021 to April 2022. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 896-6780.

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7F6B95AC0A4D1...

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Directors, CCHCS
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Cycle 6

Medical Inspection Report

for

The California City Correctional Facility

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
June 2023

OIG