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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

September 2025

Cycle 7

Medical Inspection Report

California State Prison Sacramento

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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 7, the OIG continues to apply the same assessment methodologies used in Cycle 6, including clinical case review and compliance testing. Together, these methods assess the institution's medical care on both individual and system levels by providing 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. Through these methods, the OIG evaluates the performance of the institution in providing sustainable, adequate care. We continue to review institutional care using 15 indicators as in prior cycles.[3]

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). In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff. The OIG determines a total compliance score for each applicable indicator and considers the MIT scores in the overall conclusion of the institution's compliance performance.

In conducting in-depth quality-focused reviews of randomized cases, our case review clinicians examine whether health care staff 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. At the same time, our clinicians consider whether institutional medical processes led to identifying and correcting individual or system errors, and we examine whether the institution's medical system mitigated the error. The OIG rates each applicable indicator ***proficient***, ***adequate***, or ***inadequate,*** and considers each rating in the overall conclusion of the institution's health care performance.

In contrast to Cycle 6, the OIG will provide individual clinical case review ratings and compliance testing scores in Cycle 7, rather than aggregate all findings into a single overall institution rating. This change will clarify the distinctions between these differing quality measures and the results of each assessment.

[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.

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of California State Prison, Sacramento (SAC), the institution had not been delegated back to the department by the receiver.

We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from December 2023 to May 2024.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between July 2023 and May 2024, cardiopulmonary resuscitation reviews between October 2023 and May 2024, and specialized medical housing reviews between December 2023 and June 2024.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of SAC in December 2024. OIG inspectors monitored the institution's delivery of medical care that occurred between December 2023 and May 2024.

The OIG rated the case review component of the overall health care quality at SAC ***inadequate***.

The OIG rated the compliance component of the overall health care quality at SAC ***inadequate***.

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 67 cases, which contained 1,032 patient-related events. They 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. After examining the medical records, our clinicians completed a follow-up on-site inspection in December 2024 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our physicians rated 20 ***adequate,*** and five ***inadequate***.

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 387 patient records and 1,114 data points and used the data to answer 93 policy questions. In addition, we observed SAC's processes during an on-site inspection in August 2024.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in 13 health care indicators.[5]

[5] The indicators for **Reception Center** and **Prenatal and Postpartum Care** did not apply to SAC.

We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. SAC Summary Table: Case Review Ratings and Policy Compliance Scores

		Ratings: Proficient / Adequate / Inadequate		Scoring Ranges: 100%–85.0% / 84.9%–75.0% / 74.9%–0		
		Case Review		Compliance		
MIT Number	Health Care Indicators	Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*
1	Access to Care	Adequate	↑	83.3%	79.9%	=
2	Diagnostic Services	Adequate	=	68.1%	57.7%	=
3	Emergency Services	Inadequate	=	N/A	N/A	N/A
4	Health Information Management	Inadequate	↓	89.1%	74.3%	↑↑
5	Health Care Environment†	N/A	N/A	58.7%	49.3%	=
6	Transfers	Adequate	↑	62.3%	64.4%	=
7	Medication Management	Inadequate	=	51.5%	63.1%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	86.9%	75.7%	↑
10	Nursing Performance	Inadequate	=	N/A	N/A	N/A
11	Provider Performance	Adequate	↑	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	Adequate	=	62.5%	80.0%	↓
14	Specialty Services	Adequate	=	74.9%	61.7%	=
15	Administrative Operations†	N/A	N/A	86.6%	72.8%	↑↑

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 6 and Cycle 7. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **Health Care Environment** and **Administrative Operations** are secondary indicators and are not considered when rating the institution's overall medical quality.

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

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.[6]

The OIG found no adverse events at SAC during the Cycle 7 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to SAC. Of these 10 indicators, OIG clinicians rated six ***adequate***, and four ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 20 were ***adequate*** and five were ***inadequate***. In the 1,032 events reviewed, we identified 290 deficiencies, 66 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 SAC:

- Patients received good access to nurses and to providers for chronic care appointments.
- Providers generally made good clinical decisions, addressed their patient's chronic medical conditions appropriately, and referred their patients to specialists with follow through on the specialists' recommendations.
- Staff timely completed diagnostic tests.
- Providers and nurses made appropriate assessments for patients in the CTC.[7]
- Nurses and providers performed good assessments and follow-up appointments for newly arrived transfer patients and for patients returning from hospitalizations.

Our clinicians found the following weaknesses at SAC:

- Staff needed improvement in timely obtaining off-site specialty reports.

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

[7] CTC is the correctional treatment center.

- Staff struggled with medication continuity for patients, including those taking chronic care medications and patients with newly prescribed medications.

- Nurses needed improvement in appropriate assessments and interventions in emergency care. In addition, supervisory medical and nursing staff did not identify deficiencies when they performed clinical reviews of unscheduled emergent transfers to higher levels of care.

- Providers inconsistently addressed abnormal vital signs and documented pertinent physical examinations.

- Providers did not regularly send patient test results notification letters or, when they sent the letters, they did not consistently include all required elements in patient test results notification letters.

Compliance Testing Results

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

SAC showed a high rate of policy compliance in the following areas:

- Medical staff performed excellently in community hospital discharge reports, specialty reports, and in placing requests for health care services into patients' electronic medical records within required time frames.

- Staff always provided colorectal cancer screenings and generally provided annual TB screening and influenza vaccinations to all sampled patients.

- Primary care providers timely evaluated patients returning from outside community hospitals or specialty service appointments. Moreover, providers evaluated newly arrived patients to SAC within required time frames.

- Nursing staff processed sick call request forms, performed face-to-face assessments, and completed nurse-to-provider referrals within required time frames.

SAC revealed a low rate of policy compliance in the following areas:

- Providers sporadically communicated results of diagnostic services to patients with test result letters. Most patient notification letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.

- Nurses did not regularly inspect emergency medical response bags.

- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.

- SAC staff frequently did not maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to the specialized medical housing unit. In addition, SAC maintained poor medication continuity for patients who transferred into the institution or had a temporary layover at SAC.

Institution-Specific Metrics

California State Prison, Sacramento (SAC), is located in the city of Folsom, in Sacramento County. SAC houses maximum and high-security incarcerated patients. SAC also houses patients requiring specialized mental health programming and patients with high-risk medical concerns. SAC has three separate, self-contained facilities, each composed of eight housing blocks and a recreational yard. The institution operates multiple clinics where health care staff handle nonurgent requests for medical services. Patients requiring urgent or emergent care are treated in the triage and treatment area (TTA). Health care staff conduct screenings for patients upon their arrivals in the receiving and release (R&R) clinic. SAC also has a clinic for on-site and telemedicine specialty services as well as a CTC for inpatient services. CCHCS has designated SAC an *intermediate care institution* for medical purposes; these institutions are predominantly located in urban areas, close to care centers and specialty care providers likely to be used by a patient population with higher medical needs, for the most cost-effective care.

As of April 7, 2025, the department reports on its public tracker 76 percent of SAC's incarcerated population is fully vaccinated for COVID-19 while 53 percent of SAC's staff is fully vaccinated for COVID-19.[8]

[8] For more information, see the department's statistics on its website page titled **Population COVID-19 Tracking**.

On July 2024, the Health Care Services Master Registry showed SAC had a total population of 1,927. A breakdown of the medical risk level of the SAC population as determined by the department is set forth in Table 2 below.[9]

Table 2. SAC Master Registry Data as of July 2024

Medical Risk Level	Number of Patients	Percentage*
High 1	245	12.7%
High 2	417	21.6%
Medium	884	45.9%
Low	381	19.8%
Total	**1,927**	**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 7- 22-24.

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, SAC had one vacant executive leadership position, 1.3 primary care provider vacancies, two nursing supervisor vacancies, and 23.3 nursing staff vacancies.

Table 3. SAC Health Care Staffing Resources as of July 2024

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	6.9	17.0	108.7	137.6
Filled by Civil Service	4.0	5.6	15.0	85.4	110.0
Vacant	1.0	1.3	2.0	23.3	27.6
Percentage Filled by Civil Service	80.0%	81.2%	88.2%	78.5%	79.9%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	1.0	0	24.0	25.0
Percentage Filled by Registry	0	14.5%	0	22.1%	18.2%
Total Filled Positions	4.0	6.6	15.0	109.4	135.0
Total Percentage Filled	**80.0%**	**95.7%**	**88.2%**	**100.6%**	**98.1%**
Appointments in Last 12 Months	0	1.0	4.0	18.0	23.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	1.0	0	1.0	2.0
Adjusted Total: Filled Positions	**4.0**	**5.6**	**15.0**	**108.4**	**133.0**
Adjusted Total: Percentage Filled	**80.0%**	**81.2%**	**88.2%**	**99.7%**	**96.6%**

* 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 7 medical inspection preinspection questionnaire received on7-22-24, from California Correctional Health Care Services.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 7. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report,* the OIG obtained California Medi-Cal and Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered SAC's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only two HEDIS measures are available for comparison: **poor HbA1c control**, which measures the percentage of diabetic patients who have poor blood sugar control, and **colorectal cancer screening rates** for patients ages 45 to 75. We list the applicable HEDIS measures in Table 4.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—SAC's percentage of patients with poor HbA1c control was significantly lower, indicating very good performance on this measure.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. SAC had a 31 percent influenza immunization rate for adults 18 to 64 years old and a 74 percent influenza immunization rate for adults 65 years of age and older.[10] The pneumococcal vaccination rate was 89 percent.[11]

Cancer Screening

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—SAC's colon cancer screening rate of 73 percent, indicating very good performance on this measure.

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

[11] The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV15, and PCV20), 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 where the patient was currently housed during the inspection period.

Table 4. SAC Results Compared to State HEDIS Scores

HEDIS Measure	SAC Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**12%**	33%	26%	19%
HbA1c Control (< 8.0%) ‡	79%	–	–	–
Blood Pressure Control (< 140/90) ‡	87%	–	–	–
Eye Examinations	80%	–	–	–
Influenza – Adults (18–64)	31%	–	–	–
Influenza – Adults (65+)	74%	–	–	–
Pneumococcal – Adults (65+)	89%	–	–	–
Colorectal Cancer Screening	**73%**	40%	71%	71%

Notes and Sources

* Unless otherwise stated, data were collected in August 2024 by reviewing medical records from a sample of SAC'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 *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2023–June 30, 2024 (published April 2025); https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2023-24-Medi-Cal-Managed-Care-Physical-Health-External-Quality-Review-Technical-Report-Vol1-F1.pdf

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

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

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

Recommendations

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

Access to Care

- Health care leadership should identify the root cause(s) for the lack of consistent provider follow-up appointments after high-risk triage and treatment area (TTA) events and should implement remedial measures as appropriate.

Diagnostic Services

- Health care leadership should evaluate the root cause(s) for untimely completion, acknowledgement, and notification of STAT laboratory test results and should institute remedial measures as appropriate.

Emergency Services

- Nursing leadership should analyze the root cause(s) for nurses not completing thorough assessments, reassessments, and documentation of emergent and urgent events and should implement remedial measures as appropriate.

- Executive leadership should reassess the March 27, 2024, memo, titled "Clarification of Emergency Medical Response," to determine the challenges to staff activating the medical alarm when warranted to prevent nursing assessment delays in the TTA.

Health Information Management

- The department should develop strategies, such as an electronic solution, to ensure providers create patient letters when they endorse test results and ensure patient letters contain all elements required by CCHCS policy. The department should implement remedial measures as appropriate.

Health Care Environment

- Health care leadership should determine the root cause(s) for staff not following all required universal hand hygiene precautions and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs are regularly inventoried and sealed and should implement remedial measures as appropriate.

Transfers

- Nursing leadership should identify the root cause(s) for receiving and release (R&R) nurses not completing initial health screenings, including answering all questions and documenting an explanation for each "yes" answer. Leadership should implement remedial measures as appropriate.

Medication Management

- Medical leadership should determine the root cause(s) of challenges related to medication continuity for chronic care patients, transfer-in patients, transfer-out patients, hospital discharge patients, en route patients, specialized medical housing patients, and patients prescribed new medications. Leadership should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for nursing staff not documenting patient medication refusals and no-shows in the medication administration record (MAR), as described in CCHCS policy and procedures, and leadership should implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should develop strategies to ensure nurses perform thorough face-to-face assessments as well as triage sick calls appropriately for urgent symptomatic issues and should implement remedial measures as indicated.

Provider Performance

- Medical leadership should identify the root cause(s) of providers not addressing abnormal vital signs or documenting pertinent physical examinations and should implement appropriate remedial measures.

Specialty Services

- Health care leadership should determine the root cause(s) of challenge(s) to ensuring specialty reports are received and scanned in a timely manner and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) of challenges to timely providing specialty appointments, including preapproved specialty appointments for transfer-in patients, and should 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 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.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (83.3%)**

Compared with Cycle 6, case review found SAC improved in patient access to care. Providers and nurses usually evaluated patients timely for chronic care appointments and after hospitalizations. However, patients only sometimes received follow-up provider appointments after TTA encounters. After reviewing all aspects of care access, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed satisfactory performance in this indicator. Nurses always reviewed patient sick call requests and, if the patients needed an appointment, nurses frequently completed face-to-face patient appointments timely. Provider appointments often occurred for chronic care patients, newly transferred patients, patients returning after specialty service appointments, and patients returning after hospitalizations. Based on the overall **Access to Care** compliance score result, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 113 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events requiring the institution to generate appointments. We identified 19 deficiencies relating to **Access to Care**, seven of which were significant.[12]

Access to Care Providers

SAC's performance varied with access to provider appointments. Although compliance testing showed fair access to chronic care follow-up appointments (MIT 1.001, 76.0%), SAC needed improvement with nursing-to-provider referral appointments (MIT 1.005, 66.7%). OIG clinicians identified no significant patterns of deficiencies with timely completion of provider appointments.

[12] Deficiencies occurred in cases 1–3, 10, 11, 13, 18–20, 22, 24, 26, 27, 32, 39, and 64. Significant deficiencies occurred in cases 1, 3, 10, 18, 19, and 64.

Access to Clinic Nurses

SAC performed well in access to nurse sick calls and provider-to-nurse referrals. Compliance testing showed nurses always triaged sick call requests the same day they received them (MIT 1.003, 100%) and almost always performed face-to-face appointments timely (MIT 1.004, 93.8%). OIG clinicians reviewed 42 nursing sick call requests and did not identify any deficiencies related to clinic nurse access.

Access to Specialty Services

SAC showed mixed performance with access to specialty services. Compliance testing showed satisfactory completion of routine-priority appointments (MIT 14.007, 80.0%) but sporadic completion of high-priority (MIT 14.001, 40.0%) and medium-priority appointments (MIT 14.004, 33.3%) as ordered by the providers. Staff always timely completed follow-up appointments for medium-priority appointments (MIT 14.006, 100%) and almost always timely completed subsequent follow-up for routine-priority appointments (MIT 14.009, 90.0%). In addition, SAC usually offered timely follow-up appointments for high-priority services (MIT 14.003, 80.0%). OIG clinicians found most specialty appointments occurred within requested time frames. However, we identified seven deficiencies, three of which were significant.[13] The following are examples:

- In case 3, the provider requested an initial medium-priority specialty appointment with the neurologist. However, this specialty appointment did not occur before the end our review period and was already 20 days late at that time.

- In case 26, the provider requested a medium-priority dermatology appointment, which occurred three days late.

Follow-Up After Specialty Services

Compliance testing showed very good access to provider appointments after specialty services (MIT 1.008, 89.7%). OIG clinicians identified one deficiency related to provider follow-up after specialty services as follows:

- In case 18, the patient did not receive a follow-up provider appointment after a high-priority neurosurgery specialty consultation.

Follow-Up After Hospitalization

SAC provided good access to provider follow-up appointments for patients who were discharged from a community hospital. Compliance testing showed satisfactory completion of follow-up appointments (MIT 1.007, 78.3%) within the required time frame. OIG clinicians did not identify any access deficiencies in provider follow-up appointments after hospitalizations.

[13] Deficiencies occurred in cases 3, 19, 22, 26, 27, and 64.

Follow-Up After Urgent or Emergent Care (TTA)

Providers often evaluated their patients following triage and treatment area (TTA) events when medically indicated. OIG clinicians evaluated 37 TTA events and identified three deficiencies in provider follow-up appointments for high-risk events:

- In case 1, TTA staff evaluated the patient with seizures on two separate occasions. After each event, a five-day provider follow-up appointment did not occur as required by policy.

- In case 10, the patient presented to the TTA with chest pain and shortness of breath. However, a five-day provider follow-up appointment did not occur.

Follow-Up After Transferring Into SAC

Compliance testing showed excellent access to intake appointments for newly arrived patients (MIT 1.002, 95.7%). OIG clinicians did not find any deficiencies with provider access for new transfers in patients.

Clinician On-Site Inspection

OIG clinicians interviewed health care leadership, supervising staff, providers, and nurses. We learned SAC had three main clinics. Each clinic was staffed with two or three on-site providers, and one clinic had a telemedicine provider. The clinics were staffed with registered nurses (RNs), licensed psychiatric technicians (LPTs), licensed vocational nurses (LVNs), and medical assistants (MAs). Except for the LPTs, staff members had their appointment schedule and co-consulted with providers either when patient concerns could not be addressed through nursing protocol or if the MA identified abnormal vital signs. The office technicians (OTs) reported having intermittent provider backlogs during the review period, which they attributed to a large influx of medically complex, lower security level patients to one of the yards. These patients generated more frequent encounters due to their medical conditions and increased utilization of specialty services.

OIG clinicians attended morning huddles in the clinic and the CTC. The morning clinic huddle lasted about 30 minutes and included discussions about TTA and specialty encounters from the previous day as well as pertinent expiring medications. Custody staff and medication line nurses attended and participated in the huddle. During the CTC huddle, the patient care team thoroughly reviewed each patient housed in the unit. Mental health providers were available for consultation on behavioral issues or adjustments to patients' mental health medications.

OIG clinicians met with the scheduling supervisor who reported no staffing vacancies during the review period. The scheduling supervisor stated appointments were intermittently rescheduled due to yard disruptions from the frequent fights and assaults on staff. The scheduling supervisor reported most appointments were rescheduled within required time frames.

Compliance Testing Results

Three of six housing units randomly tested at the time of inspection had access to health care services request forms (CDCR Form 7362) (MIT 1.101, 50.0%). In two housing units, custody officers did not have a system in place for restocking the forms. The custody officers reported relying on medical staff to replenish the forms in the housing units. The remaining housing unit did not have these forms at the time of our inspection.

Compliance Score Results

Table 5. 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)	19	6	0	76.0%
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)	22	1	2	95.7%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	32	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	30	2	0	93.8%
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)	8	4	20	66.7%
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)	2	0	30	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)	18	5	0	78.3%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	35	4	6	89.7%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	3	0	50.0%
				Overall percentage (MIT 1): 83.3%

* 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 6. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002)	2	0	0	100%
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)	6	9	0	40.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	8	2	5	80.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	5	10	0	33.3%
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	0	9	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	9	1	5	90.0%

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

Recommendations

- Health care leadership should identify the root cause(s) for the lack of consistent provider follow-up appointments after high-risk triage and treatment area (TTA) events 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 7, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (68.1%)**

Case review found SAC performed satisfactorily in this indicator. We did not identify any deficiencies in the completion of laboratory or radiology tests. Providers usually endorsed laboratory tests timely. However, providers only occasionally communicated tests results to their patients with complete notification letters. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

SAC compliance testing performed variably for this indicator. Staff always completed laboratory services as ordered as well as timely retrieved, reviewed, and endorsed pathology reports. In addition, staff generally completed radiology services, and providers reviewed and endorsed radiology results, within specified time frames. However, providers performed poorly in generating complete patient test result notification letters with all required elements. Furthermore, staff needed significant improvement in the untimely completion, acknowledgement, and notification of STAT laboratory test results. Based on the overall **Diagnostic Services** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 204 diagnostic-related events and identified 81 deficiencies, one of which was significant.[14] All 81 deficiencies related to health information management and none related to delayed completion of ordered tests. Of the 81 deficiencies, 79 related to patient notification letters missing some of the required elements or not being sent at all, and two related to delayed endorsement of laboratory tests. Although we identified a high number of deficiencies, the deficiencies did not significantly increase the risk of harm to patients.

Test Completion

SAC performed variably in timely completing diagnostic tests. Compliance testing showed excellent performance in completing radiology services (MIT 2.001, 90.0%) and laboratory tests (MIT 2.004, 100%) within required time frames. However, compliance testing revealed the institution performed poorly in completing STAT laboratory services

[14] Deficiencies occurred in cases 1, 2, 9, 10–15, 17–23, 25, 26, 28, 29, and 64–66. A significant deficiency occurred in case 10.

(MIT 2.007, 40.0%). OIG clinicians did not identify any deficiencies related to diagnostic test completion, including STAT laboratory testing.

Health Information Management

SAC performed satisfactorily in managing the results of diagnostic tests. Compliance testing showed providers always endorsed laboratory results timely (MIT 2.005, 100%) and generally endorsed radiology results timely (MIT 2.002, 80.0%). OIG clinicians identified two deficiencies related to the late endorsement of test results.[15] The following is an example:

- In case 10, the provider endorsed a laboratory test result eight days late.

Staff performed perfectly in pathology report retrieval (MIT 2.010, 100%), provider review of pathology reports (MIT 2.011, 100%), and provider communication of STAT laboratory results (MIT 2.009, 100%) within specified time frames. However, compliance testing revealed either providers never acknowledged STAT laboratory tests or nursing staff did not notify providers of the results within the required time frame (MIT 2.008, zero). OIG clinicians did not identify any deficiencies related to STAT or pathology test result retrieval or endorsement.

Compliance testing revealed providers performed poorly in communicating test results to patients with complete notification letters. Providers sporadically communicated results with complete letters for radiology (MIT 2.003, 40.0%), laboratory (MIT 2.006, 37.5%), and pathology (MIT 2.012, 30.0%) studies within required time frames. OIG clinicians found 79 deficiencies related to provider communication of test results. Providers either sent incomplete notification letters to their patients or did not send them at all.[16]

We discuss this further in the **Health Information Management** indicator.

Clinician On-Site Inspection

The OIG clinicians interviewed the senior laboratory assistant and the correctional health services administrator (CHSA). They reported staff shortages during the review period. During the review period, no full-time radiology technician was available, and laboratory services had two laboratory assistants covering the entire institution. Despite these staff shortages, the institution did not have a backlog of radiology or laboratory appointments. The supervisor reported having sufficient coverage on the weekend from a radiology technician to complete all requested imaging studies. In addition, the two laboratory assistants worked to ensure all laboratory orders were timely completed.

SAC offered routine X-rays, CTs, MRIs, and ultrasounds onsite.[17] Staff also performed FibroScans when needed.[18] The CHSA reported no backlog in diagnostic studies.

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[15] Deficiencies occurred in cases 10 and 25.

[16] Minor deficiencies in patient notification letters occurred in cases 1, 2, 10–15, 17–23, 25, 26, 28, 29, and 64–66.

[17] A CT is a computed, or computerized, tomography scan while an MRI is a magnetic resonance imaging scan. Both create detailed images of the organs and tissues to detect diseases and abnormalities.

[18] A FibroScan is a diagnostic imaging scan used to evaluate for liver scarring and fatty changes from liver disease.

Providers reported no problems with obtaining laboratory or imaging studies, and they did not have any issues with retrieving STAT laboratory results. The providers also did not experience any difficulties with obtaining microbiology or pathology studies.

Compliance Score Results

Table 7. 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)	9	1	0	90.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	8	2	0	80.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	4	6	0	40.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	3	5	2	37.5%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	4	6	0	40.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	0	10	0	0
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	10	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	3	7	0	30.0%
				Overall percentage (MIT 2): 68.1%

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

Recommendations

- Health care leadership should evaluate the root cause(s) for untimely completion, acknowledgement, and notification of STAT laboratory test results and should institute 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 solely through case review.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Not Applicable***

Case review found SAC performed unsatisfactorily in providing emergency care. Providers generally performed well in urgent and emergent events. Nurses performed satisfactorily in providing CPR and administering Narcan. However, nurses continually struggled with performing thorough nursing assessments and providing appropriate interventions in emergent events. SAC staff needed improvement in activating medical alarms when patients needed transport to the TTA for further evaluation. In addition, when the institution's chief nurse executive (CNE) and chief medical executive (CME) or designees conducted clinical reviews, they frequently did not identify the same deficiencies OIG clinicians identified. Considering all factors, the OIG rated this indicator ***inadequate.***

Case Review Results

We reviewed 37 urgent or emergent events and found 47 emergency care deficiencies. Of these 47 deficiencies, 18 were significant.[19]

Emergency Medical Response

SAC's health care staff and first responders promptly responded to emergencies and generally intervened when required. Of the 37 responses to urgent or emergent events we reviewed, 21 events occurred as the result of a medical alarm activation, 13 events occurred when patients were escorted or walked unescorted to a medical area for urgent or emergent medical issues, and in the remaining three events, nursing or custody staff requested medical assistance by phone. Of the 37 events, we identified delays in four cases, which we discuss below.

SAC's executive leadership reported a change in emergency response due to the increase in medical emergencies on the A Yard. SAC's leadership implemented an emergency

[19] Deficiencies occurred in cases 1–5, 7, 9, 10, 18, and 22–24. Significant deficiencies occurred in cases 2–5, 9, 10, 18 and 24.

medical process that included two components. First, SAC generated a memorandum on March 27, 2024, titled "Clarification of Emergency Medical Response," which specified first responders, including custody staff, would determine the best means of activating the emergency medical response system, assess the level or urgency of the response needed, and control movement of the incarcerated population. Second, SAC leadership activated a TTA on the A Yard (also referred to in case records as the "A Yard TTA," the "rotunda," or the "clinic") in addition to the main TTA; however, during the clinician on-site inspection, the A Yard TTA was deactivated. Our clinicians received conflicting information about when the deactivation occurred because nursing leadership informed us it had been deactivated in March 2024; however, the clinicians reviewed case records indicating the continued use of the A Yard TTA until May 2024.

Despite the intentions of this emergency medical process, we identified multiple significant delays and staff confusion about how to implement the memorandum's direction. We elevated the following examples to nursing leadership:

- In case 2, nurses promptly responded to a medical alarm for this patient with an altered level of consciousness. Upon arrival, the RN assessed the patient, who was moaning in pain with slightly labored respirations and an elevated pulse. Staff transported the patient to the rotunda via a gurney and further assessed the patient, rather than transporting the patient directly to the main TTA. Ten minutes later, the patient continued to have labored breathing, and staff transported him to the main TTA. While enroute to the main TTA, the patient's oxygen saturation rate significantly decreased. The RN placed oxygen on the patient and initiated 9-1-1 via radio. This 10-minute delay in transport to the main TTA placed the patient at significant risk.

- In case 9, at 6:58 p.m., first responders activated an alarm requesting medical assistance. At 6:59 p.m., nursing staff responded to the medical emergency but were delayed in performing a full assessment. The nurse documented the patient was "alert and agitated, skin pink and no respiratory issues were evident." The nurse further documented the patient was combative and documented custody staff informed medical staff the "scene was unsafe." Twenty-two minutes later, custody staff requested medical assistance for a second time. At 7:21 p.m., the RN documented the patient was unresponsive with agonal respirations and a nonpalpable carotid pulse.[20] Because the record contained no documentation of what occurred in the 22 minutes before the patient became unresponsive, we identified this as a serious delay in care.

- In case 10, first responders activated medical alarms on 7/28/23 and 8/28/23 for this patient with breathing problems. In both emergency events, an RN responded to the patient's location and decided to have the patient remain in the housing unit for a breathing treatment in his cell instead of transporting the patient to the TTA for further evaluation and care. In addition, this nurse did not notify the provider of either event. Furthermore, on 12/21/23, first responders again activated a medical alarm. Nursing staff responded to the

[20] Agonal breathing is a serious physical sign indicating a medical emergency, and the patient's body is not getting enough oxygen. A nonpalpable carotid pulse means the pulse in the main artery in the neck cannot be felt with physical examination. This may indicate the heart is not pumping blood effectively, revealing a potentially serious medical condition.

patient for a complaint of shortness of breath and found the patient to be in severe respiratory distress; however, the nurse did not activate 9-1-1 until eight minutes later.

- In case 18, nursing staff was notified of this patient complaining of chest pain. Nursing staff responded to the patient's location, obtained vital signs, and transferred the patient to the TTA via gurney. The patient had a recent history of hospitalization for a bleed in the brain due to an assault. The TTA RN documented the patient was somewhat lethargic and drowsy, had a dragging gait, and showed signs of concentration difficulties and weakened strength in upper and lower extremities. The TTA nurse did not immediately activate 9-1-1 and delayed notifying the provider until twenty minutes after the patient arrived to the TTA. In addition, the nurse documented vital signs were stable but did not document the results and not did perform a blood sugar check for the patient.

Cardiopulmonary Resuscitation Quality

During the review period, we reviewed six cases in which CPR was performed.[21] In most cases, the first responder initiated CPR and administered an initial dose of Narcan without delay. The following significant findings are listed below:

- In cases 5 and 9, the first responders activated alarms for these unresponsive patients. In both cases, we identified delays in initiating CPR, administrating Narcan, and activating 9-1-1. Furthermore, in both cases, nursing staff did not administer additional doses of Narcan when each patient did not respond to the first dose administered.

Provider Performance

Providers performed well overall in urgent and emergent situations, and in after-hours care. For continuity of care, the primary care providers were responsible for their patients who presented to the TTA during the day. OIG clinicians identified one deficiency related to emergency care as follows:

- In case 3, the nurse informed the provider of this patient presenting with symptoms consistent with an acute stroke. The provider documented a plan to administer aspirin. However, the provider should have ordered an urgent CT scan of the head to rule out a head bleed prior to administering aspirin.

Nursing Performance

Nurses timely evaluated patients in urgent and emergent events; however, we found nurses needed improvement in the areas of assessment and intervention. The following are examples:

- In case 2, nursing staff responded to a medical alarm for this patient with an altered level of consciousness. Upon arrival, the nurse documented the patient was alert, moaning with pain, and had slightly labored breathing. The

[21] Staff performed CPR in cases 4–9.

nursing staff assessed the patient in the housing unit but did not assess the patient's lung sounds and did not check the patient's blood pressure. Nursing staff determined the patient required transport to the TTA 10 minutes later, due to the patient's continued labored breathing. While en route to the TTA, the patient had a sudden decline in mental status, and his oxygen level fell to a critically low level. Upon arrival to the TTA, the patient was no longer able to respond verbally, only responding to voice and pain, and the patient exhibited shallow, labored, and irregular breathing. Although nursing staff administered oxygen and initiated 9-1-1, nursing staff did not administer Narcan to rule out an overdose when the patient became altered, and the nurses did not check the patient's blood sugar to ensure the patient did not have a critical blood sugar level.

- In case 3, staff activated a medical alarm for this patient, who was slumped over in his cell with an altered level of consciousness. The LVN promptly responded to the patient, obtained vital signs including a critically low blood pressure, and notified the RN; however, the RN did not arrive until thirteen minutes later. Upon arrival, the RN found the patient had symptoms of low blood pressure and dizziness. Staff transported the patient to the unit medical clinic for further evaluation. During the nursing assessment, the patient became dizzy upon standing. The RN obtained critically low blood-pressure readings but did not perform a thorough assessment and delayed contacting the provider. Staff transported the patient to the TTA and then transferred him to a higher level of care.

- In case 24, first responders escorted the patient to the LVN for reported symptoms of chest pain, feeling anxious, and feeling his heart beating harder than normal. The LVN obtained the patient's vital signs and contacted the TTA to report the symptoms and the vital sign results. The TTA RN did not assess the patient but instead instructed the LVN to contact the on-call provider for orders. The LVN obtained a one-time order for clonidine and administered the medication to the patient.[22] Nursing staff did not document the patient's condition or disposition upon discharge from the clinical area and did not refer the patient to a mental health clinician for further evaluation.

Nursing Documentation

Nurses usually documented sufficiently for emergent events; however, we identified some incomplete documentation and a pattern of discrepancies in the documentation timeline. Examples are listed below:

- In cases 3, 7, 18, and 24, timeline discrepancies were identified.

- In cases 10 and 23, nursing staff provided care but did not document an assessment or progress note.

[22] Clonidine is a medication to treat high blood pressure and can help reduce opioid withdrawal symptoms.

Emergency Medical Response Review Committee

Compliance testing showed SAC's emergency medical response review committee (EMRRC) performed well (MIT 15.003, 83.3%). OIG clinicians reviewed 14 events and found 10 deficiencies, two of which were significant.[23] SAC EMRRC met monthly, and in most cases, OIG clinicians found the EMRRC performed timely reviews and frequently completed review packages. The SRNs performed clinical reviews of emergency responses and unscheduled transports, but did not identify the same training issues identified by OIG clinicians in several cases with urgent and emergent events

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians spoke with TTA staff. The TTA had two urgent bays, each equipped with a treatment cart for emergent or urgent patients, two standard bays equipped with procedure carts, and one observation room. The TTA had one emergency response vehicle. The overnight shift was staffed with two RNs. The day and evening shifts were staffed with three RNs per shift. The TTA staff and the SRN reported the TTA had no assigned provider. Each provider would cover their assigned patient panel, and providers rotated to provide on-call coverage. All staff, including clinic staff and TTA RNs, responded to all emergency events at all hours.

OIG clinicians interviewed TTA nurses. The nursing staff reported having a good relationship with custody staff. Nursing staff reported feeling supported by nursing leadership and experiencing good morale.

[23] EMRRC deficiencies occurred in cases 1–5, 10, 18, and 24. Significant deficiencies occurred in cases 3 and 18.

Recommendations

- Nursing leadership should analyze the root cause(s) for nurses not completing thorough assessments, reassessments, and documentation of emergent and urgent events and should implement remedial measures as appropriate.

- Executive leadership should reassess the March 27, 2024, memo, titled "Clarification of Emergency Medical Response," to determine the challenges to staff activating the medical alarm when warranted to prevent nursing assessment delays in the TTA.

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.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Proficient*** **(89.1%)**

In this cycle, case review found SAC's performance decreased compared with Cycle 6. Health information management (HIM) staff usually scanned documents into the electronic health records system (EHRS) appropriately.[24] Providers usually endorsed laboratory results and reports timely. However, we identified an inconsistent scanning of specialty reports. In addition, a very large number of deficiencies related to patient notification letters, as providers frequently either generated the letters without all policy required components or did not generate them at all. After careful consideration, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed SAC performed very well in health information management. Staff always timely scanned health care service request forms. In addition, staff frequently scanned specialty reports as well as scanned and reviewed hospitalization discharge documents within required time frames. Lastly, staff satisfactorily labeled medical records and scanned them into the correct patient files. Based on the overall **Health Information Management** compliance score result, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 197 events and found 101 deficiencies related to health information management, nine of which were significant.[25]

Hospital Discharge Reports

SAC's HIM staff performed well in retrieving and scanning hospital discharge documents into EHRS within required time frames (MIT 4.003, 85.0%). OIG clinicians reviewed 23

[24] EHRS is the department's electronic health record system is used for storing the patient's medical history and health care staff communication.

[25] Deficiencies occurred in cases 1, 2–4, 9-15, 17–26, 28, 29, 40, and 64–66. Significant deficiencies occurred in cases 10, 15, 18, 21, 24, 26, and 64.

off-site emergency department and hospital encounters and did not identify any deficiencies with retrieving records or scanning them into patients' charts.

Specialty Reports

SAC performed variably in managing specialty reports. Compliance testing showed staff frequently scanned specialty reports into the EHRS timely (MIT 4.002, 90.0%). Staff satisfactorily received and endorsed high-priority (MIT 14.002, 83.3%) and medium-priority (MIT 14.005, 83.3%) specialty reports within required time frames. In addition, SAC staff always timely received and endorsed routine-priority specialty reports (MIT 14.008, 100%).

OIG clinicians reviewed 71 specialty reports and identified 16 deficiencies, six of which were significant.[26] All significant deficiencies involved reports that staff did not timely scan into EHRS. We discuss these findings further in the **Specialty Services** indicator.

Diagnostic Reports

SAC needed improvement with managing diagnostic reports. Compliance testing showed providers always timely reviewed and endorsed pathology reports (MIT 2.011, 100%) but only sporadically communicated pathology results to patients with notification letters (MIT 2.012, 30.0%). OIG clinicians identified 79 deficiencies related to incomplete or missing patient results notification letters, which accounted for almost all diagnostic health information management deficiencies.[27] We also identified infrequent late provider endorsements of diagnostic results.[28] Please refer to the **Diagnostic Services** indicator for further discussion.

Urgent and Emergent Records

OIG clinicians reviewed 23 emergency care events. Nurses and providers sufficiently recorded these events. Providers usually documented their emergency care encounters, including telephone communication with nurses when they evaluated patients in the clinic or TTA during after-hours. We did not identify any significant deficiencies or problematic patterns. The **Emergency Services** indicator provides additional details.

Scanning Performance

SAC performed satisfactorily in the scanning process. Compliance testing showed the institution usually labeled, scanned, and filed documents appropriately (MIT 4.004, 79.2%). OIG clinicians did not identify any deficiencies with HIM staff's document scanning.

Clinician On-Site Inspection

OIG clinicians discussed health information management with the health records technician (HRT) supervisor and staff, who did not report any staffing shortages during

[26] Specialty health information management deficiencies occurred in cases 3, 10, 15, 18, 19, 21, 26, 28, 29, and 64. Significant deficiencies occurred in cases 15, 18, 21, 26, and 64.

[27] Minor deficiencies occurred in cases 1, 2, 10–15, 17–23, 25, 26, 28, 29, and 64–66.

[28] Deficiencies occurred in cases 10 and 25.

the review period. We discussed the tracking process for provider endorsement of laboratory studies and reports. According to the HRT supervisor, staff performed random audits to ensure providers endorsed documents scanned into the EHRS. The HRT supervisor reported performing additional audits to check whether providers generated patient test results notification letters to include all four components as required by CCHCS policy. The supervisor stated providers have steadily improved in endorsing documents and completing patient notification letters.

Compliance Score Results

Table 8. 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	12	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	27	3	15	90.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	17	3	3	85.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	19	5	0	79.2%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	21	2	0	91.3%
				Overall percentage (MIT 4): 89.1%

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

Table 9. 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)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	0	10	0	0
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	3	7	0	30.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	10	2	3	83.3%
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)	10	2	3	83.3%
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)	14	0	1	100%

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

Recommendations

- The department should develop strategies, such as an electronic solution, to ensure providers create patient letters when they endorse test results and ensure patient letters contain all elements required by CCHCS policy. The department should implement remedial measures as appropriate.

Health Care Environment

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (58.7%)**

Overall, SAC's performance in health care environment needed improvement. Medical supply storage areas contained unorganized, unidentified, or inaccurately labeled medical supplies. Several clinics did not meet the requirements for essential core medical equipment and supplies. In addition, staff did not regularly sanitize or wash their hands during patient encounters. Lastly, emergency medical response bag (EMRB) logs were missing staff verification, and glucometer daily quality control logs were inaccurate. Based on the overall **Health Care Environment** compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Patient Waiting Areas

We inspected only indoor waiting areas as SAC had no outdoor waiting areas. Health care and custody staff reported existing waiting areas contained sufficient seating capacity. Patients waited either in the clinic waiting area or in individual modules (see Photo 1, right, and Photo 2, next page). During our inspection, we did not observe overcrowding in the indoor waiting areas of any clinic.

Photo 1. Indoor clinic patient waiting area (photographed on 8-6-24).

Photo 2. Individual waiting modules (photographed on 8-6-24).

Clinic Environment

Seven of eight applicable clinic environments were sufficiently conducive for medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 87.5%). In one clinic, the blood draw station did not provide reasonable auditory privacy, and we observed the phlebotomist discussing a patient's blood draw orders while an incarcerated porter was in the vicinity and able to overhear the conversation.

Six of eight applicable clinics we observed contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 75.0%). In two clinics, examination rooms contained unsecured confidential medical records.

Clinic Supplies

Four of eight applicable clinics followed adequate medical supply storage and management protocols (MIT 5.107, 50.0%). We found one or more of the following deficiencies in the other four clinics: expired medical supplies (see Photo 3); unorganized, unidentified, or inaccurately labeled medical supplies; and cleaning materials stored with medical supplies (see Photo 4, next page).

Photo 3. Expired medical supply dated March 2024 (photographed on 8-6-24).

Photo 4. Medical supplies stored with cleaning materials (photographed on 8-6-24).

Four of eight applicable clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 50.0%). We found one or more of the following deficiencies in the remaining four clinics: staff had not properly calibrated an oto-ophthalmoscope; one clinic had a nonfunctional oto-ophthalmoscope; staff had not completed automated external defibrillator (AED) performance test log documentations within the last 30 days; the clinic daily glucometer quality control logs were either inaccurate or incomplete; and Snellen eye charts were placed at an incorrect distance.

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only three of the six applicable EMRBs passed our test (MIT 5.111, 50.0%). In three locations, staff failed to log EMRB daily glucometer quality control test results accurately. In one of the three locations, staff failed to ensure the EMRB's compartments were sealed and intact.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found medical supplies stored beyond the manufacturers' temperature guidelines (see Photo 5 and Photo 6, next page).

According to the chief executive officer (CEO), health care leadership did not have any issues with the medical supply process. Health care and warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system in place.

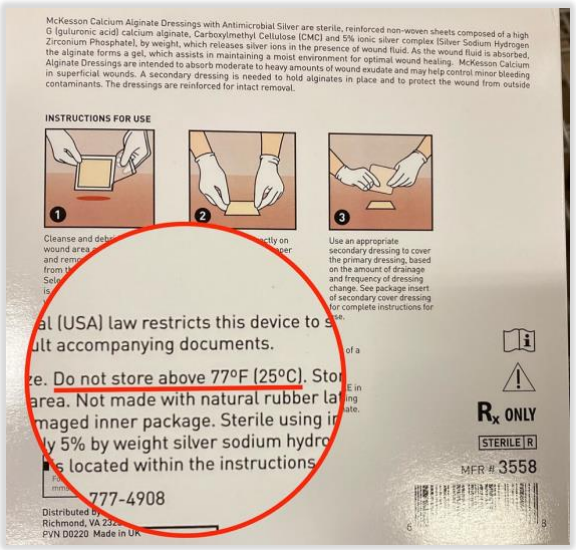

Photo 6. Medical supply not stored within manufacturer's temperature guideline (photographed on 8-6-24).

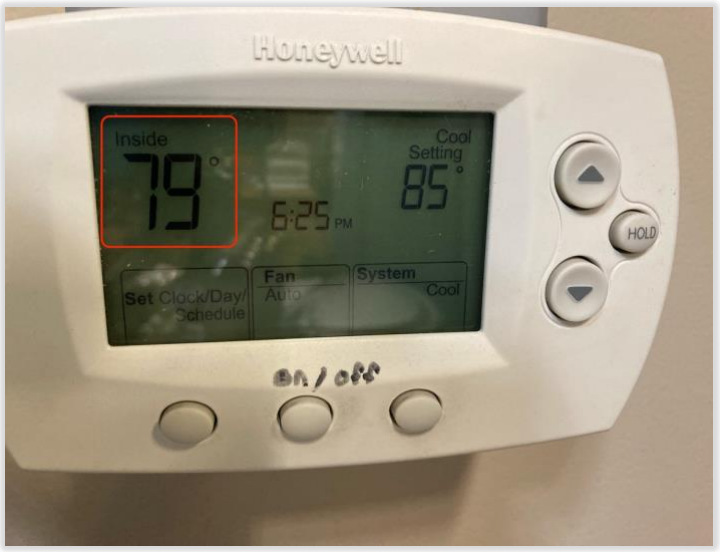

Photo 5. Warehouse temperature at the time of inspection was 79°F, and the air conditioning was not set to cool until the temperature reaches 85°F (photographed on 8-6-24).

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized five of eight applicable clinics (MIT 5.101, 62.5%). In two clinics, staff did not maintain cleaning logs. In one clinic, we found an unsanitary cabinet under the clinic sink.

Staff in seven of eight applicable clinics properly sterilized or disinfected medical equipment (MIT 5.102, 87.5%). In one clinic, staff did not mention disinfecting the examination table as part of the daily start-up protocol.

We found operational sinks and hand hygiene supplies in the examination rooms in four of eight applicable clinics (MIT 5.103, 50.0%). In the remaining four clinics, the patient restrooms lacked antiseptic soap and disposable hand towels.

We observed patient encounters in six applicable clinics. In four clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, or before each subsequent regloving (MIT 5.104, 33.3%).

Health care staff in all clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 100%).

Physical Infrastructure

SAC's health care management and plant operations manager reported all infrastructure in clinical areas was in good working order and did not hinder health care services.

At the time of our medical inspection, health care leadership reported work had started in February 2022 on the health care facility improvement program (HCFIP) project, which included replacing the HVAC system and flooring as well as renovating the clinical spaces for ADA compliance in A Facility. Health care leadership estimated the project would be completed by November 2025. They reported challenges in completing the project due to unavailability of construction labor in the general market and noted the institution was instead utilizing incarcerated labor. In addition, construction of a new pharmacy building was still in the design phase (MIT 5.999).

Compliance Score Results

Table 10. 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	1	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)	7	1	1	87.5%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	4	4	1	50.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	4	3	33.3%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	8	0	1	100%
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)	4	4	1	50.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	4	4	1	50.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	7	1	1	87.5%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	6	2	1	75.0%
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)	3	3	3	50.0%
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): 58.7%

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

Recommendations

- Health care leadership should determine the root cause(s) for staff not following all required universal hand hygiene precautions and should implement remedial measures as appropriate.
- Health care leadership should determine the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.
- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs are regularly inventoried and sealed and should implement remedial measures as appropriate.

Transfers

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (62.3%)**

Case review found SAC performed sufficiently in the transfer process. Compared with Cycle 6, providers showed improvement in completing timely follow-up appointments for patients who recently transferred into the institution. OIG clinicians also identified a decrease in the number of significant deficiencies. Nurses showed improvement in the transfer process; however, we found SAC continued to struggle with medication continuity when patients returned from the hospital. Considering all factors, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed mixed results with the transfer process. SAC performed excellently in completing the assessment and disposition sections of the screening process. In contrast, the institution scored low in completing initial health screening forms and in ensuring medication continuity for newly transferred patients. The institution also did not always ensure transfer packets for departing patients included required medications. Based on the overall **Transfers** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 48 events in 22 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room encounter. We identified 17 deficiencies, one of which was significant.[29]

[29] Deficiencies occurred in cases 2, 8, 10, 22, 24, 30–33, and 35. A significant deficiency occurred in case 32.

Transfers In

SAC's performance for the transfer-in process varied. Compliance testing showed nurses always completed the assessment and disposition section on the initial health screening form (MIT 6.002, 100%). However, the nurses frequently did not complete the screening thoroughly (MIT 6.001, 28.0%). The reasons for this low score included both nursing staff completing the initial health screening after the patient departed to the housing unit and omitting documentation of patients' weight or an explanation for "yes" answers on initial health screening forms. OIG clinicians reviewed eight transfer-in cases and found nurses performed satisfactorily in completing assessments and ordering provider appointments within required time frames. We identified four minor deficiencies, none of which were significant.[30]

Compliance testing showed SAC performed excellently with ensuring providers evaluated newly arrived patients within required time frames (MIT 1.002, 95.7%). Similarly, OIG clinicians did not identify any deficiencies with the timeliness of provider appointments for newly arrived patients.

Compliance testing revealed SAC needed improvement in medication continuity for transfer patients (MIT 6.003, 54.6%). OIG clinicians also identified concerns with medication continuity. Below is an example:

- In case 32, the patient arrived at SAC without any of his scheduled keep-on-person (KOP) medications.[31] The patient was scheduled to receive all the medications the next day; however, the patient did not receive his medication for chronic kidney disease until 14 days later and missed approximately 13 doses.

Case review and compliance testing had mixed results for timely specialty appointments. Compliance testing revealed SAC performed poorly in scheduling preapproved specialty appointments for patients who transferred into the institution (MIT 14.010, 35.0%). Analysis of the compliance scores showed SAC did not schedule patients for specialty appointments timely; the appointments occurred from 11 to 64 days late. In contrast, OIG clinicians identified two minor deficiencies, neither of which were significant.[32]

Transfers Out

SAC's performance for the transfer-out process varied and resulted in different findings between case review and compliance testing. OIG clinicians reviewed 23 events in 14 cases in which patients returned from a hospitalization or emergency room evaluation and identified four deficiencies, none of which were significant.[33] Nurses performed satisfactory assessments; however, we identified two cases in which the nurses' assessments were not thorough.

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[30] Deficiencies occurred in cases 24, 30, 31 and 32.

[31] Keep-on-person (KOP) refers to medications that a patient can keep and self-administer according to the directions provided.

[32] Deficiencies occurred in cases 24 and 32.

[33] Deficiencies occurred in cases 10, 22, and 24.

SAC performed poorly in maintaining continuity of hospital recommended medications (MIT 7.003, 35.3%). Analysis of the compliance scores showed SAC did not administer medications timely and did not discontinue medications after patients were in the hospital more than 24 hours. Please refer to the **Medication Management** indicator for further discussion.

Hospitalizations

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

OIG clinicians reviewed 23 events in 14 cases in which patients returned from an off-site hospitalization or emergency room encounter. We identified four deficiencies, none of which were significant.[34]

Compliance testing showed provider follow-up appointments occurred within required time frames (MIT 1.007, 78.3%). Case review did not identify any deficiencies. In addition, providers frequently reviewed the hospital discharge documents within required time frames (MIT 4.005, 91.3%). Most of the time, SAC staff scanned hospital or emergency room summary reports into EHRS and made reports available timely (MIT 4.003, 85.0%). Please refer to the **Health Information Management** indicator for further details.

Clinician On-Site Inspection

OIG clinicians inspected the receiving and release (R&R) unit and interviewed the R&R nurse, who was knowledgeable about the transfer process. The nurse stated an average of 20 patients transferred in daily and an average of 25 patients transferred out weekly.

Nursing staff reported high refusal rates from patients returning from the community hospital or transferring into SAC who did not want their vitals taken or other assessments performed. Additionally, nursing staff reported sometimes custody officers would provide the hospital discharge paperwork to the nursing staff without the patient present for a face-to-face evaluation upon return to the institution. In their case reviews, OIG clinicians identified patterns with patients refusing nursing assessments upon return from community hospitals and for patients transferring into the institution.

Nursing staff reported another issue they encountered with patient transfers was missing rescue inhalers. The R&R staff recently addressed this issue by including rescue inhalers as part of the medication floor stock in the R&R unit. This allowed the staff to provide rescue inhalers to patients as needed. The R&R did not have an automated drug delivery system (ADDS) available.[35] However, the nurse reported R&R nursing staff could obtain medications from the CTC ADDS if needed. According to the nurse, R&R had no

[34] Deficiencies occurred in case 10, 22, and 24.

[35] The automated drug delivery system (ADDS), also known as an automated dispensing cabinet, is used to provide drug security, and tracking for controlled substances to meet all federal and state requirements.

problems with pharmacy or equipment and reported good nursing morale as well as a supportive administration.

Compliance On-Site Inspection and Discussion

R&R nursing staff ensured two of three patients transferring out of the institution had their required medications, transfer documents, and assigned durable medical equipment (MIT 6.101, 66.7%). For one patient, the transfer packet was missing a required medication.

Compliance Score Results

Table 11. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001)	7	18	0	28.0%
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	21	0	4	100%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	6	5	14	54.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	2	1	0	66.7%
				Overall percentage (MIT 6): 62.3%

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

Table 12. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**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)	22	1	2	95.7%
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)	18	5	0	78.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	17	3	3	85.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	21	2	0	91.3%
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)	6	11	6	35.3%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	12	13	0	48.0%
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)	2	8	0	20.0%
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)	7	13	0	35.0%

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

Recommendations

- Nursing leadership should identify the root cause(s) for receiving and release (R&R) nurses not completing initial health screenings, including answering all questions and documenting an explanation for each "yes" answer. Leadership should implement remedial measures as appropriate.

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. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Inadequate* (51.5%)**

In this cycle, case review found SAC performed poorly in medication management. Case review found patients did not always receive their medications timely and without interruption for newly prescribed medications, chronic care medications, and transfer medications. Considering all factors, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed SAC needed improvement in this indicator. SAC scored low in providing patients with chronic care medications, newly prescribed medications as ordered, community hospital discharge medications, and medications for patients transferring within the institution, temporarily housed at the institution, transferring out of the institution, and housed in the specialized medical housing unit. Based on the overall **Medication Management** compliance score results, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 35 cases related to medications and found 24 medication deficiencies, eight of which were significant.[36]

New Medication Prescriptions

SAC performed poorly in ensuring administration and delivery of newly prescribed medications within required time frames (MIT 7.002, 48.0%). OIG clinicians also found a pattern of staff administering newly prescribed medications late or not at all. The following are examples:

- In case 18, the patient received a newly prescribed medication to treat his enlarged prostate six days late.
- In case 23, the nurse assessed the patient in the TTA for abdominal discomfort, and the provider prescribed medication for nausea and

[36] Deficiencies occurred in cases 2, 3, 8–10, 18, 20–25, 31–33, and 64. Significant deficiencies occurred in cases 10, 20, 21, 23, 24, and 32.

constipation to start the same day; however, the patient never received the medications.

Chronic Medication Continuity

During this review period, SAC performed poorly in chronic medication continuity. Compliance testing revealed patients rarely received their chronic care medications within required time frames (MIT 7.001, 28.6%). OIG clinicians found patients frequently did not receive chronic care medications timely or did not receive them at all.[37]

- In case 10, the provider did not renew the patient's high blood pressure medication timely, resulting in the patient missing eight days of the medication.
- In case 20, the patient did not receive his high blood pressure medication for the month of February 2024.
- In case 21, the patient was due to receive chronic care medication to treat ulcerative colitis.[38] However, the patient did not receive the medication for the month of December 2023.

Hospital Discharge Medications

We found mixed results in medication continuity for patients upon return from a community hospital. Compliance testing revealed SAC performed poorly in ensuring medications were available to the patient by the ordered administration date or time (MIT 7.003, 35.3%). OIG clinicians identified two deficiencies related to medication continuity.[39] In both deficiencies, nursing staff did not inquire whether patients with a prescribed rescue inhaler had the inhaler in their possession upon return from the hospital.

Specialized Medical Housing Medications

Compliance testing revealed SAC performed poorly in ensuring staff made medications available and administered them timely in the CTC (MIT 13.003, zero). In all samples, the pharmacy did not make medications available within required time frames. In contrast, OIG clinicians found only one deficiency related to medication management, which was not significant.[40]

Transfer Medications

Compliance testing revealed SAC performed poorly with medication continuity for patients transferring from yard to yard (MIT 7.005, 48.0%) and in ensuring staff administered or delivered medications timely for patients laying over at the institution

[37] Chronic care medications not received timely or at all occurred in cases 2, 10, 20, 21, 23, 25, and 64.

[38] Ulcerative colitis is a chronic inflammatory disease that causes inflammation and ulcers in the intestines.

[39] Deficiencies occurred in cases 10 and 22.

[40] A CTC medication deficiency occurred in case 64.

(MIT 7.006, 20.0%). In addition, SAC needed improvement in ensuring patients who transferred into the institution received medications timely (MIT 6.003, 54.6%).

Both case review and compliance testing revealed SAC needed improvement in ensuring all patients who transferred out of the institution received a five-day supply of their medications (MIT 6.101, 66.7%).

Medication Administration

Compliance testing showed SAC generally ensured staff administered tuberculosis (TB) medications as prescribed (MIT 9.001, 80.0%). However, nurses only intermittently monitored these patients correctly (MIT 9.002, 66.7%). OIG clinicians had no cases of patients taking TB medications or of TB monitoring to review.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians met with the pharmacist in charge (PIC) and nursing leadership and discussed specific questions identified during the clinical reviews. The OIG clinicians inspected the medication administration areas and spoke with LVNs. We found the nurses knowledgeable about the medication process. In addition, the LVNs attended clinic huddles and notified providers of expiring medications and other concerns related to medications.

Medication Practices and Storage Controls

SAC appropriately stored and secured narcotic medications in seven of eight applicable clinic and medication line locations (MIT 7.101, 87.5%). In one location, narcotic medications were not properly and securely stored as required by CCHCS policy.

SAC appropriately stored and secured nonnarcotic medications in seven of 12 applicable clinic and medication line locations (MIT 7.102, 58.3%). In three locations, nurses did not maintain unissued medications in original labeled packaging. In one location, the treatment cart log was missing daily security check entries. In the remaining location, the medication area lacked a clearly labeled designated area for refrigerated medications to be returned to the pharmacy.

Staff kept medications protected from physical and chemical contamination and at the proper temperature in 10 of the 12 applicable clinic and medication line locations (MIT 7.103, 83.3%). In two locations, we found one or both of the following deficiencies: staff did not store oral and topical medications separately, and the medication refrigerator was unsanitary.

Staff successfully stored valid and unexpired medications in 10 of the 12 applicable medication line locations (MIT 7.104, 83.3%). In one location, medication nurses did not label multi-use medication as required by CCHCS policy. In another location, a previously opened medication was stored beyond the manufacturer's guideline.

Nurses exercised proper hand hygiene and contamination control protocols in four of six applicable locations (MIT 7.105, 66.7%). In the remaining two locations, some nurses neglected to wash or sanitize their hands when required, including before preparing and administering medications, or before each subsequent regloving.

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

Staff in two of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 33.3%). In four locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within required time frames; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; medication nurses did not follow the CCHCS care guide when administering Suboxone medication; medication nurses did not consistently scan each medication electronically at the time of administration; medication nurses did not always verify a patient's identification using a secondary identifier; and during insulin administration, we observed some medication nurses not properly disinfecting the medication vial's port prior to withdrawing medication.

Pharmacy Protocols

SAC did not follow general security, organization, and cleanliness management protocols in its pharmacy (MIT 7.108, zero). More specifically, the medication preparation area was found cluttered at the time of inspection. In the pharmacy, staff did not properly store nonrefrigerated medication (MIT 7.109, zero). We found medications stored in containers that were inaccurately labeled or not labeled at all. The institution did not properly store refrigerated or frozen medications in the pharmacy (MIT 7.110, zero). We found an unsanitary medication refrigerator.

The pharmacist in charge (PIC) correctly accounted for narcotic medications stored in the pharmacy (MIT 7.111, 100%). We examined 12 medication error reports and found the PIC timely and correctly processed all reports (MIT 7.112, 100%).

Nonscored Tests

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

The OIG interviewed patients in restrictive housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Of the applicable patients interviewed, 24 of 28 indicated they had access to their rescue medications. At the time of our interview, four patients had their rescue inhalers in their possession; however, the inhalers were empty. We promptly notified the CEO of this concern, and health care management immediately issued replacement rescue inhalers to these patients (MIT 7.999).

Compliance Score Results

Table 13. 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)	6	15	4	28.6%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	12	13	0	48.0%
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)	6	11	6	35.3%
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)	12	13	0	48.0%
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)	2	8	0	20.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	7	1	7	87.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	7	5	3	58.3%
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)	10	2	3	83.3%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	10	2	3	83.3%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	4	2	9	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	5	1	9	83.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	2	4	9	33.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	0	1	0	0
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)	12	0	0	100%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): 51.5%

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

Table 14. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	6	5	14	54.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	2	1	0	66.7%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	12	3	0	80.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	10	5	0	66.7%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	0	2	0	0

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges related to medication continuity for chronic care patients, transfer-in patients, transfer-out patients, hospital discharge patients, en route patients, specialized medical housing patients, and patients prescribed new medications. Leadership should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for nursing staff not documenting patient medication refusals and no-shows in the medication administration record (MAR), as described in CCHCS policy and procedures, and leadership should implement remedial measures as appropriate.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as being at high risk for coccidioidomycosis (Valley Fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score. Our case review clinicians do not rate this indicator.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Proficient* (86.9%)**

SAC performed very well in this indicator. Staff performed excellently in screening patients annually for TB and offering colorectal cancer screening for patients ages 45 through 75. Staff also performed very well in offering patients an influenza vaccine for the most recent influenza season and in offering required immunizations to chronic care patients. In addition, staff performed satisfactorily in administering TB medications to patients as prescribed. However, staff needed improvement in monitoring patients on TB medications. These findings are set forth in the table on the next page. Based on the overall **Preventive Services** compliance score result, the OIG rated this indicator ***proficient***.

Compliance Score Results

Table 15. 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)	12	3	0	80.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	10	5	0	66.7%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	22	3	0	88.0%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	24	1	0	96.0%
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)	10	1	14	90.9%
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): 86.9%

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

Recommendations

The OIG offers no recommendations for this indicator.

Nursing Performance

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Not Applicable***

Case review found SAC nurses performed variably. Nurses performed satisfactorily during the transfer process and in specialized medical housing. However, nurses in emergency services and the outpatient clinics struggled to provide complete and thorough nursing assessments and interventions. We also found a pattern of untimely assessments of urgent symptomatic sick call requests. Carefully considering all factors in the quality of nursing care, the OIG rated this indicator ***inadequate.***

Case Review Results

We reviewed 200 nursing encounters in 60 cases and identified 80 nursing performance deficiencies, 14 of which were significant.[41]

Outpatient Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements. Nurses generally provided appropriate nursing assessments and interventions.

Of 89 outpatient nursing encounters, 27 were sick call requests.[42] In these encounters, our clinicians identified 43 deficiencies, four of which were significant. Of these 43

[41] Deficiencies occurred in cases 1–5, 7, 9, 10, 18–20, 22–25, 27, 30–33, 35, 40–43, 45, 47–51, 53–55, and 57–65. Significant deficiencies occurred in cases 2–5, 9, 10, 18, 19, 23, 24, 43, and 50.

[42] We reviewed sick call events in cases 10, 18–20, 24, 25, 40, 41, 43, 45, 47–51, 53–55, and 57–63.

deficiencies, 28 related to incomplete nursing assessments, which occurred when nurses in the outpatient areas did not arrange a same-day nurse appointment for urgent symptomatic issues or did not perform sufficient assessments. The following are examples:

- In cases 10, 19, 24, 25, 43, 47, and 48, we found a pattern of urgent symptomatic sick call requests in which nurses did not assess the patient the same day.

- In case 10, the patient often complained of shortness of breath or wheezing and had an active order for breathing treatments four times a day as needed. Nurses frequently provided the breathing treatments as needed; however, the nurses did not perform reassessments after administering the breathing treatments to monitor the medication effectiveness or determine whether provider notification was necessary.

- In case 18, the sick call RN reviewed a sick call request for complaint of lower extremity swelling and request for compression stockings and orthotic shoes. The nurse assessed the patient the next business day. The patient reported acute leg swelling, severe neck pain, and foot pain. The nurse did not assess the presence of lower leg swelling, inquire about pain level, assess the foot, or record which extremity was affected. In addition, the nurse did or document the patient's gait. Finally, the nurse did not review medication compliance or provide patient education.

- In case 19, the sick call RN triaged a sick call request for urgent symptoms of pulsing pain in the patient's right eye socket. The nurse did not arrange for the patient to have a same day face-to-face assessment to rule out an acute injury. Instead, staff assessed the patient three days later.

- In case 43, the sick call RN triaged a sick call request for a patient who wrote, "I think I got pneumonia once again." The nurse did not schedule the patient for a same day or next business day face-to-face assessment to rule out a lung infection. Instead, the RN scheduled the patient for an appointment in 14 days.

- In case 48, the sick call RN triaged a sick call request for the patient with symptoms of occasional chest pains and a request for weight loss drugs. The nurse did not schedule the patient for a same day face-to-face assessment to rule out a cardiac event.

- In case 50, the sick call RN assessed a patient with nasal congestion, coughing, and sneezing, who reported coughing up mucus. The nurse did not perform a COVID-19 screening or test and incorrectly documented the patient did not have a cough on the TB risk factor screening section of the form.

Outpatient Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. SAC staff generally documented care appropriately.

Case Management

OIG clinicians reviewed four cases in which a care manager evaluated the patients.[43] Nursing leadership reported the clinics' RNs perform all care management. Case review did not identify any deficiencies in scheduling or in evaluating patients for care management appointments.

Wound Care

We reviewed five cases involving wound care orders. Three patients were in the outpatient setting and two patients were in the CTC. Case Review found nursing generally provided good wound assessments and documentation.

Emergency Services

We reviewed 38 urgent or emergent events. Nurses responded promptly to emergent events. However, we found nurses needed improvement in nursing assessments, interventions, and documentation, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 23 events involving returns from off-site hospitals or emergency rooms and found nurses performed good nursing assessments. For more specific details, please refer to the **Transfers** indicator.

Transfers

We reviewed 11 cases related to transfer-in and transfer-out processes. Nurses evaluated patients appropriately and initiated provider appointments within appropriate time frames. However, nurses did not always perform thorough assessments. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed four CTC cases and found nurses performed timely assessments and generally delivered appropriate care. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

OIG clinicians reviewed seven cases with a total of 17 nursing assessments of patients returning from off-site specialist appointments. Patients frequently refused nursing assessments upon return from off-site specialty appointments. However, nurses performed appropriate assessments, reviewed specialty reports for recommendations, and co-consulted with providers when needed.

[43] A care manager assessed patients in cases 10, 23, 24, and 25.

Medication Management

OIG clinicians reviewed 162 events involving medication management and administration. We identified 24 deficiencies, eight of which were significant. Nurses generally administered medications timely and as ordered; however, on several occasions, a lapse in continuity of chronic care medications occurred. Further details are provided in the **Medication Management** indicator.

Clinician On-Site Inspection

OIG clinicians inspected each facility, which included the TTA, R&R, medical clinics, and select medication administration areas. OIG clinicians also conducted interviews with staff and supervisors. During our on-site inspection, staff reported CTC 1, which usually housed medical patients, was closed for repairs. Patients requiring CTC-level of medical care were transferred to other facilities. Our clinicians attended several huddles during our inspection. Huddles were well organized and followed the huddle script. TTA nurses reported a high patient refusal rate, especially from patients in the C Yard, upon returning from off-site specialty appointments and emergency room encounters. Nursing staff reported patients often refused because they did not want to wait for the nursing assessment and wanted to return directly back to their housing unit.

Nurses in various roles reported the working environment had improved with changes in leadership, and the overall nursing morale was "good." The nurses we interviewed reported feeling supported by their leadership and having a good rapport with custody staff.

The CNE and the supervising registered nurse (SRN) III (Acting) had been in their respective roles for more than a year. The CNE discussed some of the challenges he encountered upon taking the role at SAC, which included lack of leadership and accountability as well as staff who had lost trust in the nursing leadership team. The CNE reported a recent shift in nursing leadership, which led to a change in the overall culture of the nursing staff. This shift included steps to re-establish trust in nursing leadership, such as having daily meetings with SRN IIs to discuss any issues or problems and implementing an open-door policy for staff. This eventually led to staff wanting to join the nursing management team.

Recommendations

- Nursing leadership should develop strategies to ensure nurses perform thorough face-to-face assessments as well as triage sick calls appropriately for urgent symptomatic issues and should implement remedial measures as indicated.

Provider Performance

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Not Applicable***

SAC providers generally delivered good medical care. Compared with Cycle 6, provider performance improved significantly as providers better addressed their patients' acute and chronic conditions, made sound medical decisions, and developed appropriate treatment plans. Providers delivered satisfactory care for patients in the CTC and emergency settings. However, we identified a pattern in which providers only sometimes addressed abnormal vital signs or documented pertinent physical examination findings. In addition, providers only sometimes communicated tests results to their patients with complete notification letters. After careful consideration of all provider performance factors, the OIG rated this indicator ***adequate***.

Case Review Results

The OIG clinicians reviewed 141 medical provider encounters and identified 48 deficiencies related to provider performance, 20 of which were significant.[44] In addition, OIG clinicians rated the quality of care in 25 comprehensive case reviews. Of these 25 cases, we rated 20 ***adequate*** and five ***inadequate***.[45]

Outpatient Assessment and Decision-Making

Providers often made accurate assessments and appropriate decisions for their patients. They usually took good histories, formulated thorough differential diagnoses, and referred patients to specialists when needed. However, OIG clinicians identified 12 deficiencies related to poor assessments and decision-making.[46] The following are examples:

[44] Deficiencies occurred in cases 1–3, 10–13, 15–17, 19–21, 23–28, and 65. Significant deficiencies occurred in cases 2, 3, 10–12, 15, 16, 19, 20, 23, 24, and 26.

[45] We rated cases 3, 10, 20, 23, and 24 ***inadequate***.

[46] Deficiencies in assessments and decision-making occurred in cases 10, 16, 19–21, 23, 24, and 26.

- In case 19, the provider evaluated the patient with a history of hypertension, who complained of dizziness and near black-out episodes. The provider did not consider cardiac causes for these symptoms but ordered a routine-priority neck CT scan to evaluate for rotational vertebral artery syndrome.[47] However, given the patient's symptoms, the provider should have ordered the imaging study as high-priority to assess for reduced blood flow to the brain.

- In case 23, the provider evaluated the patient who had anemia and ordered iron supplementation tablets.[48] However, the provider did not complete a workup to determine the cause of the anemia.

- In case 26, the provider documented the patient as having an enlarging skin lesion with discharge, indicating an acute infection. However, the provider did not document a complete examination of the skin lesion or order antibiotics.

Emergency Care

In the TTA, providers appropriately managed patients with urgent and emergent conditions. In addition, providers were available for consultation with TTA staff. We identified five deficiencies related to emergency care, one of which was significant. We discuss this deficiency further in the **Emergency Services** indicator.

Specialized Medical Housing

Providers sufficiently addressed their patients' acute and chronic medical conditions while they were housed within the CTC. We identified one minor deficiency related to the provider not performing a pertinent physical examination. We also discuss specialized medical housing provider performance in the **Specialized Medical Housing** indicator.

Specialty Services

Providers usually referred their patients for specialty consultations when medically indicated. They addressed the specialists' recommendations and ordered additional services appropriately. We discuss provider performance further in the **Specialty Services** indicator.

Outpatient Review of Records

Provider review of medical records is essential to address the patient's conditions and develop an appropriate plan of care. Providers performed excellently with reviewing records. We did not identify any deficiencies related to poor review or lack of review of medical records.

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[47] Rotational vertebral artery syndrome is caused by the narrowing of the vertebral artery and results in dizziness provoked by side-to-side head movements.

[48] Anemia is a low red blood cell count, which can be caused by inadequate red blood cell production, red cell destruction, or loss of red blood cells from the body.

Patient Notification Letter

Providers inconsistently sent complete patient notification test result letters. We frequently identified instances of missing letters or letters not including the required four components per CCHCS policy. The deficiencies occurred in all detailed cases we reviewed.[49] We discuss this further in the **Diagnostics** indicator and the **Health and Information Management** indicator.

Chronic Care

Providers usually addressed their patients' chronic health conditions. They appropriately managed patients with diabetes, hypertension, and cardiovascular disease as well as patients taking chronic anticoagulation medications such as warfarin.[50] We did not identify any significant deficiencies in these areas. However, we identified a pattern in which providers did not always address abnormal vital signs or document appropriate physical examinations.[51] The following are examples:

- In case 10, the provider evaluated the patient at a follow-up appointment. The patient complained of weakness during this encounter, but the provider did not address the patient's abnormally low blood pressure. The provider should have considered adjusting the patient's blood pressure medications to reduce the risk of future hypotension.

- In case 20, the provider evaluated the patient at a follow-up appointment but did not address the patient's abnormally low heart rate. The patient was taking a beta-blocker, a medication that lowers the heart rate. However, the provider did not document a plan to adjust this medication, which increased the likelihood of further lowering the heart rate.[52]

- In case 26, the provider evaluated the patient, who complained of visual floaters.[53] However, the provider did not perform a detailed eye examination or test for visual acuity.

Outpatient Documentation Quality

Documentation ensures a patient's care plan is up-to-date and appropriate. We did not identify any significant problems with provider documentation; however, we found two minor deficiencies related to the absence of documentation.[54]

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[49] Deficiencies related to incomplete patient notification letters occurred in cases 1, 2, 9–15, 17–23, 25, 26, 28, and 29.

[50] Warfarin is a blood thinning medication.

[51] Deficiencies related to not addressing abnormal vital signs occurred in cases 10, 20, and 24. Deficiencies related to providers not documenting appropriate physical examinations occurred in cases 3, 10, 13, 17, 21, 24, 26–28, and 65.

[52] A beta-blocker is a medication used to treat high blood pressure and certain heart conditions. It works by lowering the heart rate.

[53] Visual floaters are shapes in a person's vision, appearing to be spots, lines, specks, strings, or cobwebs. The floaters may be caused by age-related changes or more serious eye conditions.

[54] Documentation deficiencies occurred in cases 25 and 26.

Outpatient Provider Continuity

SAC provided excellent provider continuity for patients. The providers managed and knew their patients well. If providers were away from the office, other clinic providers would care for their patients.

Clinician On-Site Inspection

The OIG clinicians attended the morning provider meeting and clinic huddles. During the provider meeting, the on-call provider reported on significant overnight events and patients who either returned from or transferred to a higher level of care. In addition, the utilization management nurse provided updates on patients who were currently hospitalized, including any patients with post-discharge needs. The providers and nurses exhibited a detailed understanding of their patients.

The OIG physician met with the CME and the chief physician and surgeon (CP&S). Medical leadership stated SAC had no provider vacancies, but they were utilizing one telemedicine provider and another registry provider. The CME reported some difficulty in retaining providers due to the complex nature of the institution's patients. They mentioned SAC patients, including those in the restricted housing unit (RHU), were among the most challenging patients within the correctional system due to the patients' mental health conditions and difficult behaviors. The leadership stated patients often assaulted staff. Leadership assisted the providers in co-managing complex patients, including participating in legal proceedings.

Many of the providers reported poor morale. They described being "overworked" with an increasing number of clinical responsibilities without a commensurate increase in the time allotted to complete required tasks. Most providers stated their patient panels included highly complex patients with severe psychiatric conditions, which made managing their medical conditions even more difficult. At times, the providers felt unsafe due to inmate attacks on staff, which occurred frequently. In addition, they reported an influx of lower security level inmates who were medically complex and required many specialty services in addition to care coordination between several disciplines.

The providers reported the ISUDT program resulted in an increased workload of about 30 percent since CCHCS headquarters required all patients with a history of substance use disorder to be seen every 90 days, irrespective of whether the patient was receiving medication assisted treatment (MAT) or undergoing cognitive behavioral intervention (CBI).[55] The MAT appointments required additional documentation and completion of a detailed form in the EHRS, which took a significant amount of time. Some providers stated they regularly worked two to three hours beyond their scheduled shift to complete their assignments and paperwork. The providers also reported the lack of meaningful behavioral interventions for the patients in the MAT program, including input from the patients' psychiatrist in the care plan for patients with co-existent mental health disorders. The providers mentioned the on-call responsibilities were "difficult," and one provider reported sometimes receiving up to "70" calls per day. These responsibilities

[55] ISUDT is the Integrated Substance Use Disorder Treatment program. MAT is the Medication Assisted Treatment program for substance use disorder. CBI is a form of treatment that helps patients manage their conditions and problems by changing their thinking and behavior.

were somewhat alleviated by the introduction of a rotating, nocturnal telemedicine provider, who would take most of the overnight calls four days per week.

Although providers expressed feeling overwhelmed with significant and increasing responsibilities, the providers felt supported by their medical leadership. They felt comfortable raising their concerns regarding especially difficult patients or presenting challenging cases to the group.

Recommendations

- Medical leadership should identify the root cause(s) of providers not addressing abnormal vital signs or documenting pertinent physical examinations and should implement appropriate remedial measures.

Specialized Medical Housing

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. At the time of our inspection, SAC's specialized medical housing consisted of a correctional treatment center (CTC).

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (62.5%)**

Case review found SAC performed satisfactorily in the CTC. Compared with Cycle 6, nursing had fewer deficiencies. Case review found CTC nurses performed timely assessments and generally delivered appropriate care. The OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed SAC needed improvement with specialized medical housing care. CTC providers performed excellently in timely completing history and physical examinations. In contrast, nursing staff needed improvement in timely completing admission assessments and ensuring medication administration for newly admitted patients in specialized medical housing. Based on the overall **Specialized Medical Housing** compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed four CTC cases involving 10 provider events and 25 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified seven deficiencies, none of which were significant.[56]

Provider Performance

Providers delivered good care within the CTC. Compliance testing showed providers completed all admission history and physicals without delay (MIT 13.002, 100%). OIG clinicians found providers made accurate assessments and decisions, exhibited appropriate medical decision-making, and ensured patients received required specialty

[56] Deficiencies occurred in cases 64 and 65.

consultations. We did not identify any significant provider deficiencies affecting CTC patients.

Nursing Performance

Case review found CTC nurses performed sufficiently. We reviewed 25 nursing events and identified four deficiencies related to nursing performance, none of which were significant.[57] CTC nurses conducted regular rounds and generally provided thorough assessments and appropriate care plans.

Case review found CTC nurses performed initial patient assessments timely. Compliance testing revealed only two applicable samples, in one of which the nurse did not complete the admission assessment timely (MIT 13.001, 50.0%). In this sample, the nurse completed the patient assessment 10 hours after admission.

Medication Administration

Case review identified one deficiency related to medication management in the CTC.[58] In contrast, compliance testing revealed SAC performed poorly in ensuring patients admitted to the CTC received their medications within required time frames (MIT 13.003, zero). Please refer to the **Medication Management** indicator for further details.

Clinician On-Site Inspection

At the time of our on-site inspection, nursing leadership reported the medical CTC unit had been temporarily closed since July 12, 2024, due to heating, ventilation, and air conditioning (HVAC) repair. Leadership reported patients who required medical inpatient beds were transferred to other institutions.

Compliance On-site Inspection and Discussion

At the time of the on-site inspection, CTC 1 was temporarily closed for HVAC system repair. CTC 2 had a functional call light communication system (MIT 13.101, 100%).

[57] Deficiencies occurred in cases 64 and 65.

[58] A deficiency occurred in case 64.

Compliance Score Results

Table 16. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	1	1	0	50.0%
Was a written history and physical examination completed within the required time frame? (13.002)	2	0	0	100%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	0	2	0	0
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	1	0	1	100%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	2	N/A
				Overall percentage (MIT 13): 62.5%

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

Recommendations

The OIG offers no recommendations at this time.

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.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (74.9%)**

Case review found SAC performed acceptably in specialty services. SAC generally provided sufficient access to specialists. Providers generally endorsed specialty reports timely and followed specialists' recommendations. However, we identified a pattern of staff inconsistently scanning specialty reports into EHRS. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed mixed performance in this indicator. Staff performed excellently in retrieving and endorsing specialty reports timely. In contrast, access to off-site specialists ranged from sufficient to poor. Staff performed very well in providing timely follow-up specialty service appointments. However, preapproved specialty services for newly arrived patients only occasionally occurred within required time frames. Based on the overall **Specialty Services** compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 97 events related to **Specialty Services**, 62 of which were specialty consultations. We identified 26 deficiencies in this category, nine of which were significant.[59]

Access to Specialty Services

SAC performed variably in arranging timely access to specialists. Compliance testing showed staff performed sufficiently in providing timely routine-priority (MIT 14.007, 80.0%) specialty appointments. However, staff performed poorly in providing timely medium-priority (MIT 14.004, 33.3%) and high-priority (MIT 14.001, 40.0%) specialty appointments. Compliance testing showed the institution always provided timely medium-priority (MIT 14.006, 100%) follow-up specialty appointments and almost always provided timely routine-priority (MIT 14.009, 90.0%) follow-up specialty appointments. In addition, staff generally provided follow-up specialty appointments for high-priority referrals (MIT 14.003, 80.0%). In contrast, they performed poorly in ensuring specialty

[59] Deficiencies occurred in cases 2, 3, 10, 15, 18, 19, 21, 22, 25–29, and 64. Significant deficiencies occurred in cases 3, 15, 18, 19, 21, 26, and 64.

access for patients who transferred into the institution with preapproved specialty requests (MIT 14.010, 35.0%). OIG clinicians identified three deficiencies with specialty access, all of which were significant.[60] The following are examples:

- In case 3, the provider requested a medium-priority neurology specialty appointment. However, this appointment did not occur during before the end of our review period and was already 20 days late at that time.

- In case 19, an addiction medicine specialist follow-up appointment occurred 108 days late.[61]

Provider Performance

Providers ordered appropriate specialty consultations and followed specialists' recommendations. In addition, providers ensured their patients had appropriate follow-up with specialists for care continuity. OIG clinicians did not identify any deficiencies in providers not addressing specialists' recommendations or ordering appropriate follow-up appointments. Providers almost always endorsed specialty reports timely, and we only identified one minor deficiency.

Nursing Performance

Although patients frequently refused nursing assessments when returning from off-site specialty appointments, nurses usually performed appropriate assessments, reviewed specialty reports for recommendations, and co-consulted with the providers when needed. OIG clinicians reviewed 17 specialty events in seven cases and identified two deficiencies. However, these deficiencies did not affect the overall care patients received.

Health Information Management

SAC performed variably in health information management of specialty services. Compliance testing showed staff generally received and reviewed medium-priority (MIT 14.005, 83.3%) and high-priority (MIT 14.002, 83.3%) specialty reports timely. Staff always received and reviewed reports for routine-priority (MIT 14.008, 100%) specialty services within the required time frame. Compliance testing showed very good performance in retrieving and scanning specialty reports into EHRS within required time frames (MIT 4.002, 90.0%). However, OIG clinicians identified a pattern in which HIM staff did not always timely scan specialty documents into EHRS. We found 16 health information management deficiencies; 15 deficiencies included at least one document scanned late or not at all, and one deficiency involved an untimely provider endorsement.[62] The following are examples:

- In case 15, HIM staff scanned an endocrinology specialty report into EHRS 135 days late.

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[60] Deficiencies occurred in cases 3, 19, and 64.

[61] An addiction medicine specialist is a provider with experience and training to evaluate, diagnose, treat, and manage patients with addiction disorders and substance-related disorders.

[62] Deficiencies occurred in cases 3, 10, 15, 18, 19, 21, 26, 28, 29, and 64. Case 10 included a late provider endorsement of an echocardiogram result. Significant deficiencies occurred in cases 15, 18, 21, 26, and 64.

- In case 18, HIM staff did not scan an oncology specialty report into EHRS.

We also discuss this in the **Health Information Management** indicator.

Clinician On-Site Inspection

The OIG clinicians met with the HRT supervisor to discuss specialty report retrieval and scanning. The supervisor mentioned having an internal tracking system to ensure documents were received timely from various on-site and off-site specialty providers and hospitals. HIM staff reported close coordination with the specialty nurses to ensure documents were received timely. Through their internal tracking, HIM staff reported scanning most documents they received into the chart within one to two business days.

We discussed specialty services care with the specialty SRN and nurses, who reported no current backlog in on-site specialty services. On-site specialty services included audiology, an ocularist, optometry, orthotics, and physical therapy.[63] SAC utilization management (UM) nursing staff and SAC providers reported most specialists were readily accessible due to the urban location of the institution. The specialty nurses mentioned a significant backlog of appointments for the telemedicine addiction medicine specialty appointments, which were entirely coordinated by CCHCS headquarters. They also reported an intermittent backlog for off-site orthopedic surgery services and attributed this demand to the high frequency of altercations at the facility.

Staff stated patients usually returned from off-site specialty appointments with preliminary written recommendations for care plans and follow-up appointments. When telemedicine appointments occurred, the specialty nurses would sometimes directly message the providers with the specialists' recommendations. The specialty nurses would later receive the complete specialty reports. The nurses reported difficulty in timely receiving off-site and telemedicine specialty reports despite numerous attempts to retrieve the reports. HIM staff echoed these concerns and stated they would immediately scan the reports once received but often received these reports after the five-day compliance period. HIM and specialty services stated they would repeatedly reach out and follow up on missing specialty reports but often were unable to receive them.

[63] An ocularist is an eye specialist who makes and manages artificial eyes for patients.

Compliance Score 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)	6	9	0	40.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	10	2	3	83.3%
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	2	5	80.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	5	10	0	33.3%
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)	10	2	3	83.3%
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	0	9	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	12	3	0	80.0%
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)	14	0	1	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	9	1	5	90.0%
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)	7	13	0	35.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	18	2	0	90.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	16	3	1	84.2%
				Overall percentage (MIT 14): 74.9%

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

Table 18. Other Tests Related to Specialty Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	35	4	6	89.7%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	27	3	15	90.0%

* 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.

Recommendations

- Health care leadership should determine the root cause(s) of challenge(s) to ensuring specialty reports are received and scanned in a timely manner and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) of challenges to timely providing specialty appointments, including preapproved specialty appointments for transfer-in patients, and should implement remedial measures as appropriate.

Administrative Operations

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Proficient* (86.6%)**

SAC performed very well in this indicator. While SAC scored satisfactorily to excellently in most applicable tests, it needed improvement in two areas. Staff either did not conduct live medical emergency response drills for each shift or had incomplete documentation for the most recent quarter. In addition, SAC's physician managers only occasionally completed annual performance appraisals in a timely manner. These findings are set forth in the table on the next page. Based on the overall **Administrative Operations** compliance score result, the OIG rated this indicator ***proficient***.

Compliance Testing Results

Nonscored Results

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

We obtained CCHCS mortality case review reporting data. In our inspection, for seven patients, we found no evidence in the submitted documentation that the preliminary mortality report had been completed. The reports were overdue at the time of the OIG's inspection (MIT 15.998).

Compliance Score 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)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	10	2	0	83.3%
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)	4	0	0	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	7	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	3	4	1	42.9%
Did the providers maintain valid state medical licenses? (15.106)	12	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 3 for CCHCS-provided staffing information.			
				Overall percentage (MIT 15): 86.6%

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

Recommendations

The OIG offers no recommendations for this indicator.

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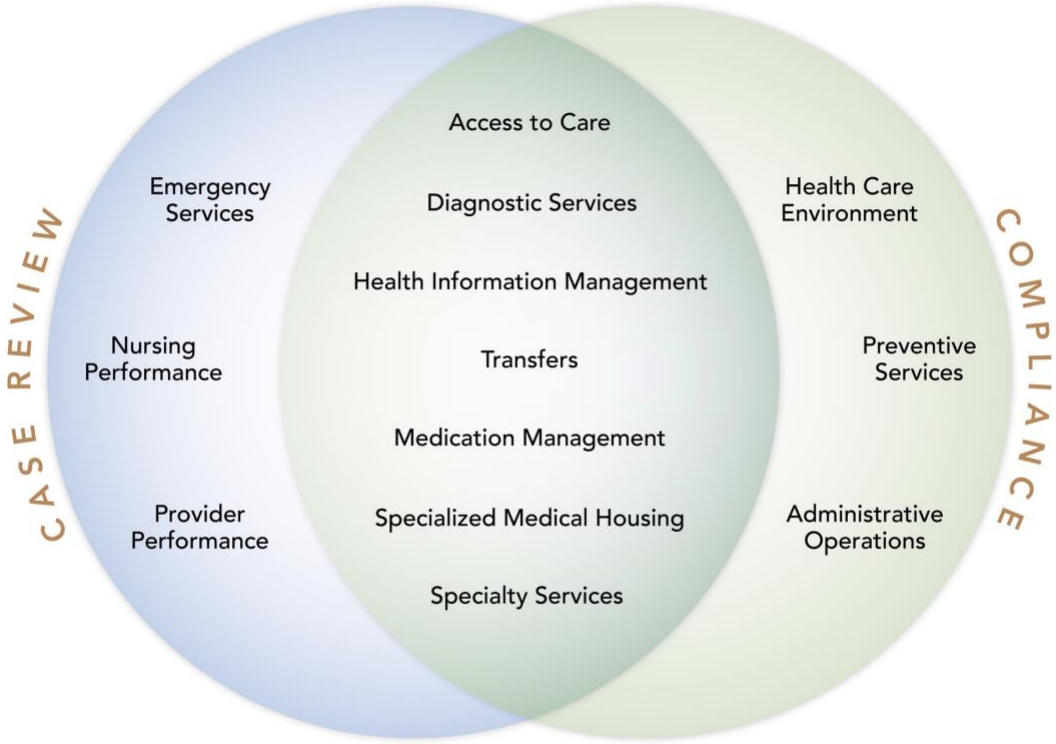
Appendix A: Methodology

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 SAC



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 7 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

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

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

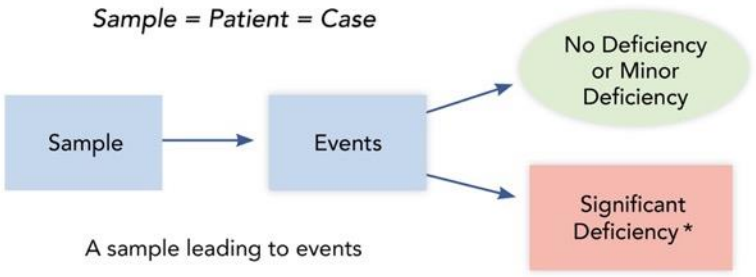
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

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

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

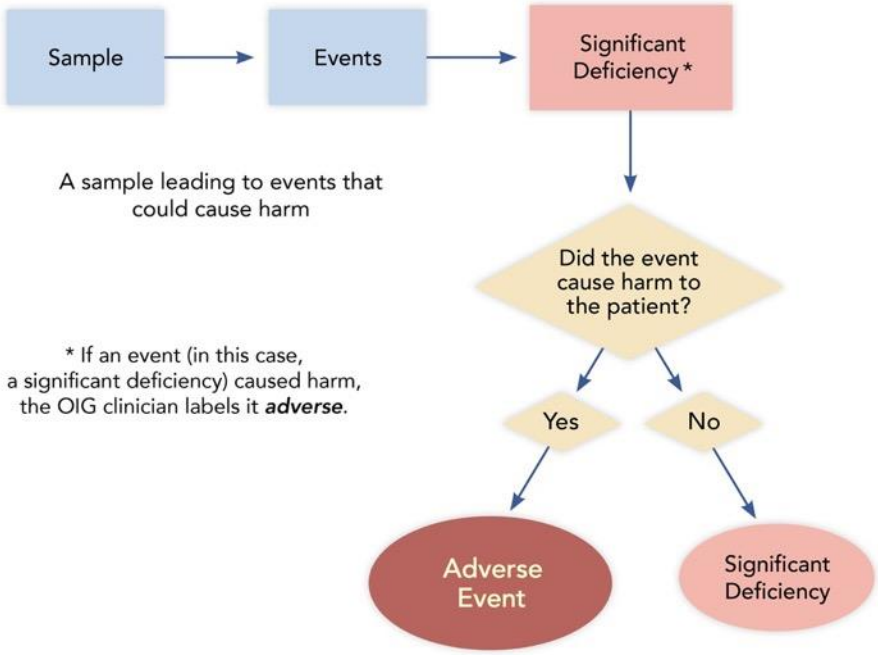
Figure A–2. Case Review Testing

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



Deficiencies

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



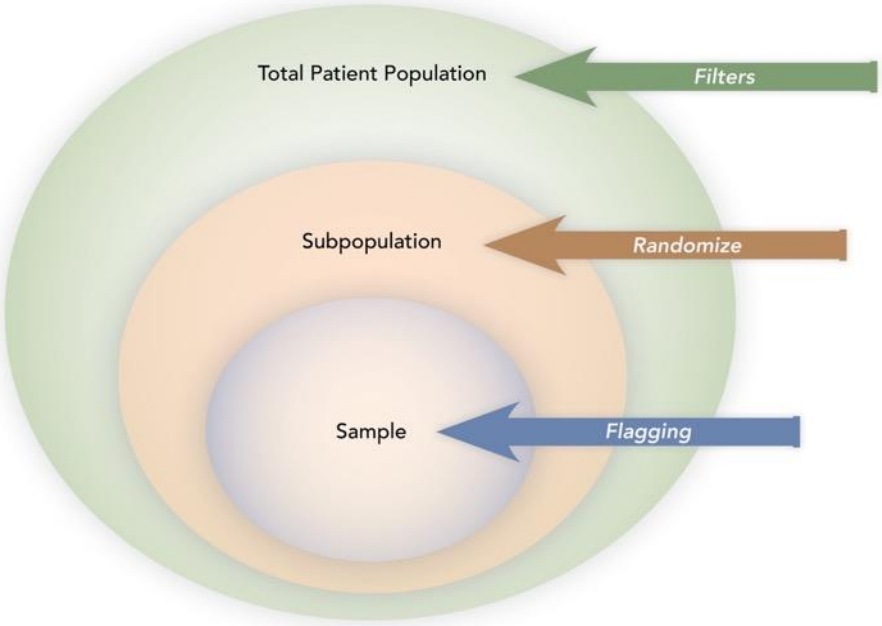
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A–3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

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

Indicator Ratings and the Overall Medical Quality Rating

The OIG medical inspection unit individually examines all the case review and compliance inspection findings under each specific methodology. We analyze the case review and compliance testing results for each indicator and determine separate overall indicator ratings. After considering all the findings of each of the relevant indicators, our medical inspectors individually determine the institution's overall case review and compliance ratings.

Appendix B: Case Review Data

Table B–1. SAC Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	4
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	28
Specialty Services	4
	67

Table B–2. SAC Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	5
Anticoagulation	5
Arthritis/Degenerative Joint Disease	10
Asthma	11
Cancer	5
Cardiovascular Disease	3
Chronic Kidney Disease	6
Chronic Pain	18
Cirrhosis/End-Stage Liver Disease	4
Coccidioidomycosis	1
COPD	3
COVID-19	1
DVT/PE	4
Diabetes	14
Gastroesophageal Reflux Disease	18
HIV	1
Hepatitis C	24
Hyperlipidemia	25
Hypertension	36
Mental Health	31
Migraine Headaches	5
Rheumatological Disease	1
Seizure Disorder	3
Sleep Apnea	2
Substance Abuse	30
Thyroid Disease	6
	272

Table B–3. SAC Case Review Events by Program

Diagnosis	Total
Diagnostic Services	233
Emergency Care	64
Hospitalization	34
Intrasystem Transfers In	17
Intrasystem Transfers Out	9
Outpatient Care	476
Specialized Medical Housing	51
Specialty Services	148
	1,032

Table B–4. SAC Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	25
MD Reviews Focused	4
RN Reviews Detailed	15
RN Reviews Focused	35
Total Reviews	79
Total Unique Cases	67
Overlapping Reviews (MD & RN)	12

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Appendix C: Compliance Sampling Methodology

California State Prison, Sacramento

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)	32	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	23	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, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, 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	32	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	23	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested incarcerated person	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	23	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	9	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	25	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	10	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	12	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	30	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	15	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	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	2	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	All	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, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender 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, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
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, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	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	4	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)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.103	Death Reports	7	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	7	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	12	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
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	CCHCS Mortality Case Review	7	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

Docusign Envelope ID: 584F6822-24C1-4DB1-B041-D530B9F869B1

September 24, 2025

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

Dear Ms. Singh:

California Correctional Health Care Services has reviewed the draft Medical Inspection Report for SAC conducted by the Office of the Inspector General from December 2023 to May 2024. Thank you for preparing the report.

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

Sincerely,

DocuSigned by:
DeAnna Gouldy

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

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

Cycle 7

Medical Inspection Report

for

California State Prison, Sacramento

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
September 2025

OIG