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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

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Summary and Trend Analysis of the OIG's Seventh Cycle of Medical Inspections

November 2022 – April 2026

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Introduction

California Penal Code section 6126 assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR or the department). Under subdivision (f), the OIG conducts an objective medical inspection program, which consists of periodically reviewing and reporting on the delivery of the medical care provided to incarcerated people in each of the department's adult prisons.

This report examines and analyzes trends across all California prison institutions through OIG's seventh cycle of medical inspections. The Cycle 7 medical inspection process for these 31 institutions began in November 2022 and concluded in August 2025, and we published the report for the final institution of this cycle in April 2026. This report also compares the inspection results of these same institutions across Cycles 4, 5, 6, and 7, as the inspection processes were similar for these four cycles. However, due to minor differences in these processes, the cross-cycle comparisons are not exact.

Two indicators, Prenatal & Postpartum Care and Reception Centers, applied to only two and three institutions, respectively. For this reason, the OIG generally omitted the results in those two indicators when discussing department-level recommendations, and their compliance scores have not been included in department averages for this report.

Readers desiring a more detailed review of any specific institution should refer to the individually published Cycle 7 medical inspection reports on the OIG's website, www.oig.ca.gov.

Methodology

In Cycle 7, the OIG applied similar assessment methodologies used in Cycles 4, 5, and 6, including clinical case review and compliance testing. Specifically, our case review clinicians, composed of a team of physicians and nurse consultants — program review (NCPRs), examined whether providers and nurses used sound medical judgment during the course of patients' treatments, then qualitatively rated the medical care across multiple health care indicators.[1] Our compliance registered nurse (RN) inspectors collected data to quantitatively assess compliance- and performance-related measures as established in the OIG's Policy Compliance Medical Inspection Tool (MIT).[2] We developed our testing requirements directly from the department's Health Care Department Operations Manual (HCDOM),[3] which contains the department's own predetermined policies to provide sustainable, acceptable care. Taken together, these methods provide a comprehensive overview of how an institution's health care system functions.

While we continued in Cycle 7 to review institutional health care using the methodologies over the same 15 indicators, the OIG altered the manner in which we reported our medical inspection findings. Specifically, beginning in Cycle 7, instead of providing a single overall rating for an institution, the OIG began providing two separate ratings: one rating from case review and one from compliance testing. Neither the methodologies nor the factors for consideration changed. However, we determined separating the ratings from each component more clearly communicates the OIG's findings, and the separate ratings better facilitate comparable analyses across institutions.

In addition, during Cycle 7, we developed a new tracking system that allowed us to better track and analyze performance trends both across the past four cycles as well as within this single cycle. In this report, we present both our cross-cycle and Cycle 7 cross-institution analyses.

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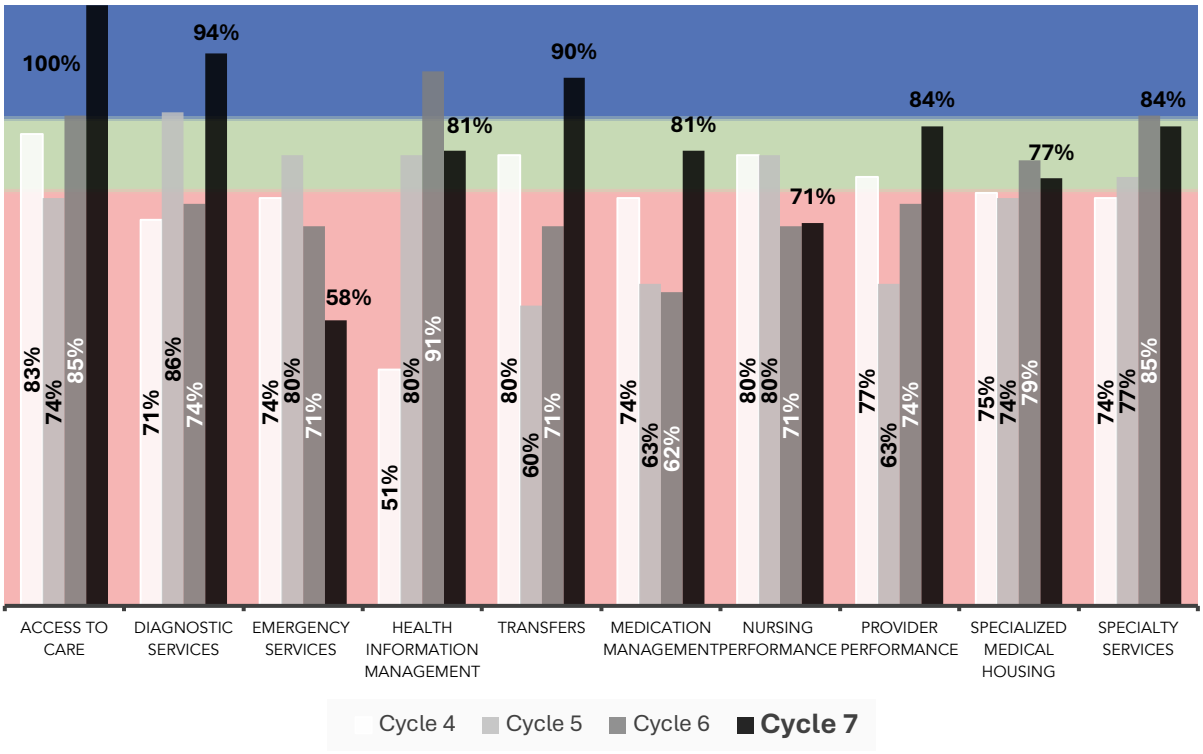
1. We evaluate the quality of healthcare across 15 indicators. Each indicator represents a set of unique components that are necessary for a successful correctional healthcare system. The 15 indicators of healthcare are: Access to Care, Diagnostic Services, Emergency Services, Health Information Management, Health Care Environment, Transfers, Medication Management, Prenatal & Postpartum Care, Preventive Services, Nursing Performance, Provider Performance, Reception Centers, Specialized Medical Housing, Specialty Services, and Administrative Operations.
2. Our medical inspection tool (MIT) is publicly available for review at: www.oig.ca.gov/dataExplorer/MIU Compliance Tool
3. The OIG's medical inspection oversight is unique in that we tailor our compliance testing to mirror this correctional health care organization's own established rules and requirements. When the department updates its policies and its requirements in the HCDOM, the OIG similarly updates our policy-compliance testing to reflect the department's changes. If a necessary health system compliance standard or timeline is not defined in the HCDOM, our compliance methodology applies OIG standards and timeframes that we based on currently accepted community and correctional health care statutes, regulations, and guidelines.

Summary and Analysis of Cross-Cycle Trends and Cycle 7 Cross-Institution Trends

Cross-Cycle Summary and Trends

The OIG commends the department for the institutions' progress in employing good clinical judgment and decision-making, as evaluated by our case review physicians and NCPRs. Figure 1 below compares the percent of institutions that passed the case review component of each indicator over the past four cycles.

Figure 1. Percentage of Institutions with Passing Case Review Scores by Indicator, Cycles 4 through 7



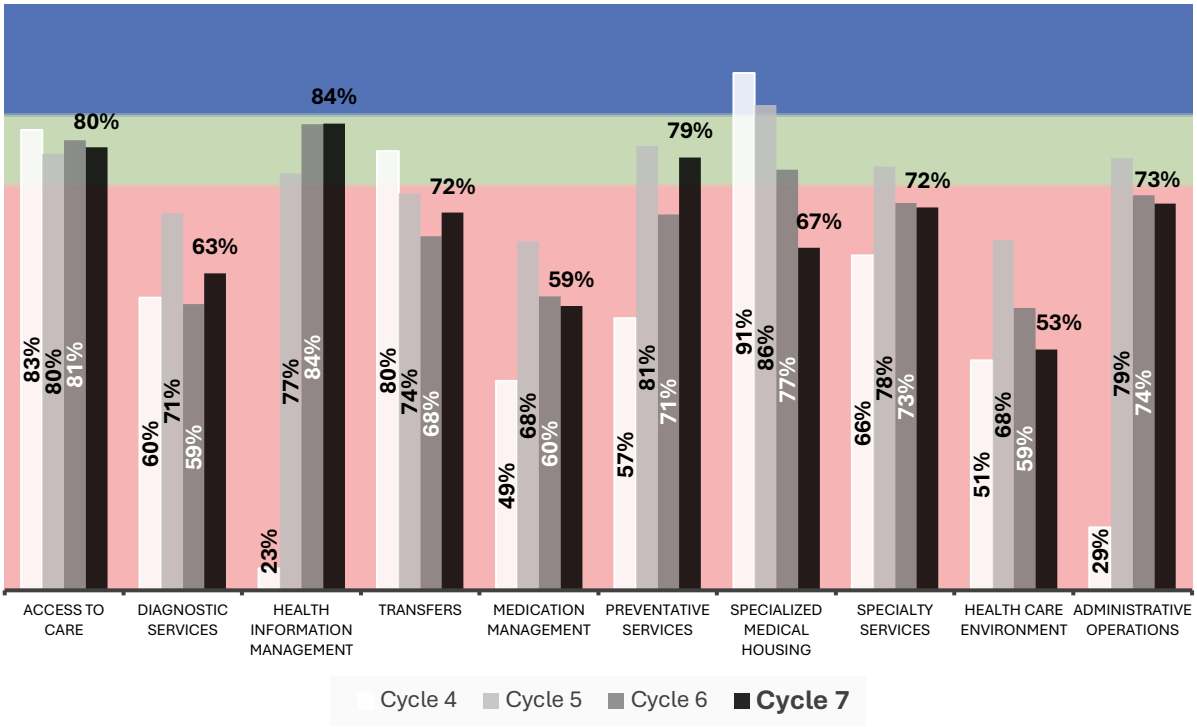
Source: OIG Medical Inspection results, www.oig.ca.gov.

As reflected in Figure 1 above, average performance across most indicators reveals sustained improvement in the percent of institutions passing the case review component of each indicator over the past four inspection cycles. The department should be recognized for the substantial progress achieved over successive inspection cycles in improving the clinical quality of patient care.

In contrast to the gains observed in the case review indicators, the compliance indicators reflected mixed performance across the inspection cycles. Performance

trends through the compliance indicators were less consistent overall in the percent of institutions passing the compliance testing components, with several indicators demonstrating stagnation at a low passing percent or decline in the passing percent. Figure 2 below compares the percent of institutions that passed the compliance component of each indicator over the past four cycles.

Figure 2: Percentage of Institutions with Passing Compliance Scores by Indicator, Cycles 4 through 7



Source: OIG Medical Inspection results, www.oig.ca.gov.

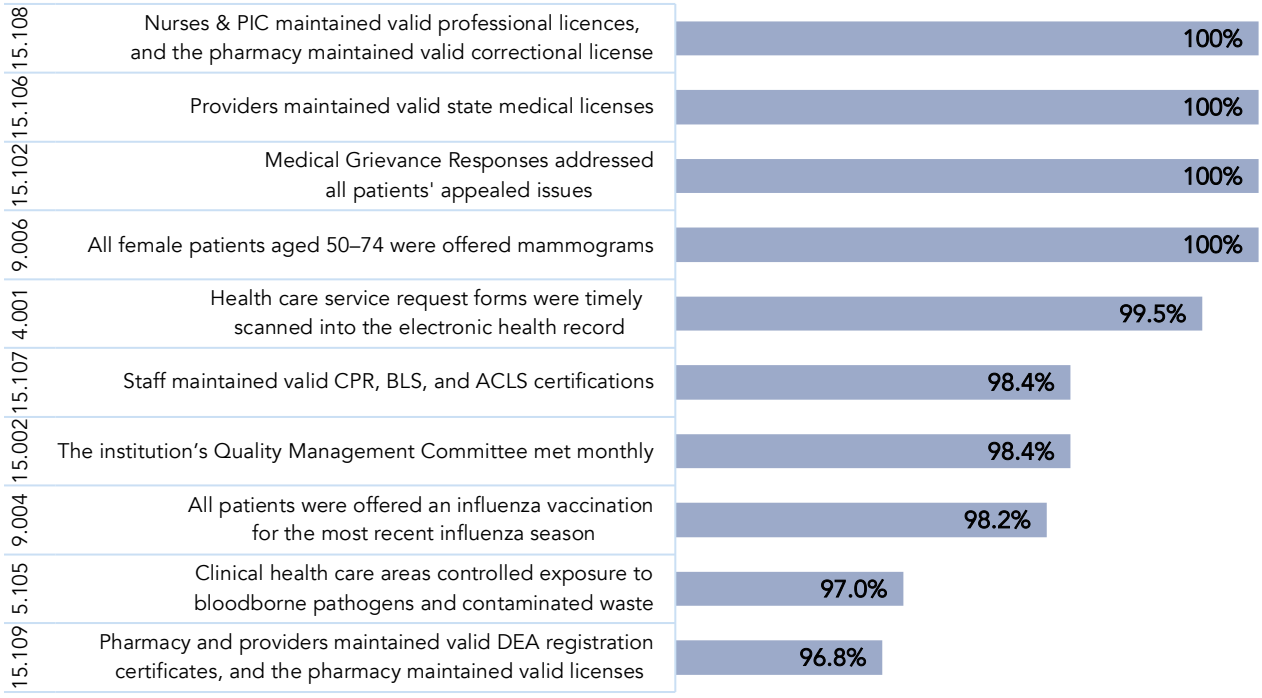
As indicated in Figure 2, two indicators maintained strong cross-institution performance over at least the past three cycles: Access to Care and Health Information Management. Three indicators showed modest improvements since Cycle 6 in the percent of institutions passing: Diagnostic Services, Transfers, and Preventive Services; however, the passing percent remained low in Diagnostic Services. The remaining five indicators all experienced decreases in the percent of passing compliance scores over at least the past three cycles: Medication Management, Specialized Medical Housing, Specialty Services, Health Care Environment, and Administrative Operations. Two of those indicators, Medication Management and Health Care Environment, both fell to low cross-institution passing levels in Cycle 7. The inconsistent performance in the compliance component across institutions and across the past four cycles highlights ongoing challenges in sustaining and standardizing systemic compliance with departmental expectations.

Cycle 7 Cross-Institution Summary and Trends

Next, we studied department-wide performance trends across the institutions in Cycle 7, comparing those indicators in which institutions generally all demonstrated strong performance as well as those indicators in which institutions uniformly struggled. First, by bifurcating the ratings between the case review and compliance components of our inspections, we found 74.2 percent (nearly three quarters) of institutions achieved overall ***adequate*** ratings in the case review component, indicating generally strong cross-institution performance in clinical judgment and decision-making in this most recent cycle. In contrast, only 25.8 percent (just over one quarter) of the institutions achieved overall ***adequate*** ratings in the compliance component. In further analyzing cross-institution performance in the compliance tests in each indicator, we further identified interesting common factors correlating with the areas of cross-institutional proficiency and inadequacy.

Specifically, the highest-performing compliance measures reflected strong institutional performance in regulatory, administrative, and documentation-based requirements, as demonstrated in Figure 3.

Figure 3. Top 10 Compliance Test Scores, Cycle 7



Source: OIG Medical Inspection results, www.oig.ca.gov.

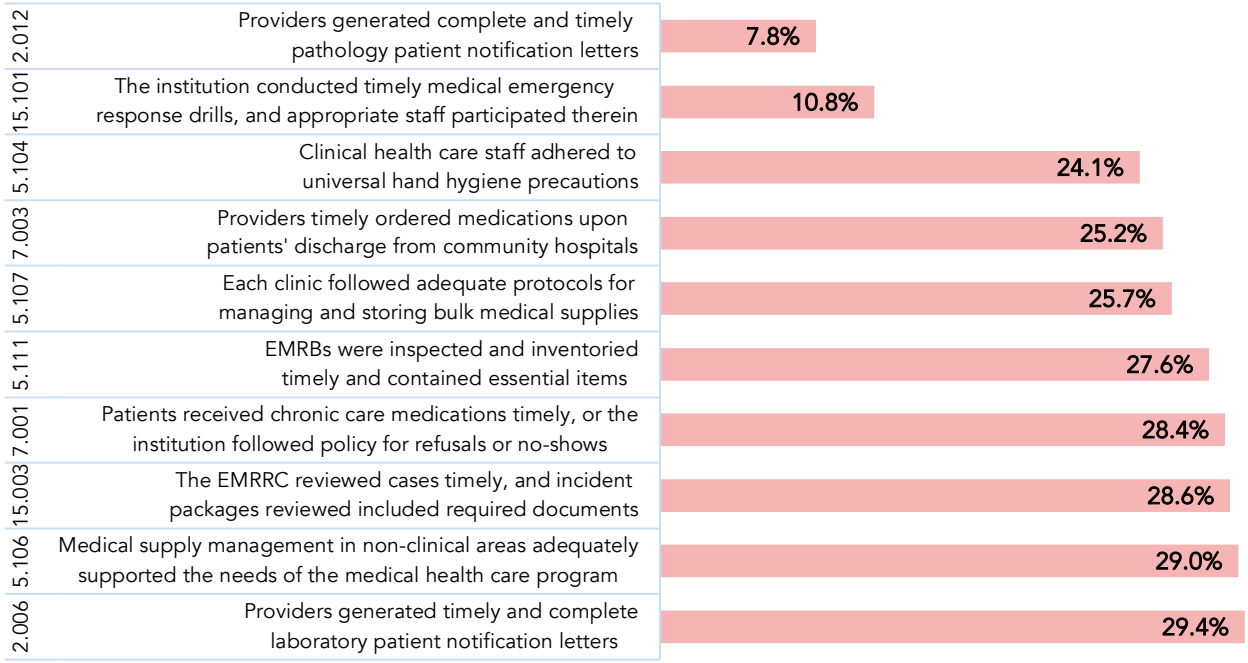
Tests involving professional licensure, certification maintenance, grievance response procedures, electronic health record documentation, and preventive care consistently

achieved perfect to near-perfect scores in every institution. The cross-institution proficiency in these tests suggests the department has successfully implemented cross-institution processes to meet these highly standardized, policy-driven expectations. For example, all institutions scored perfectly in maintaining necessary pharmacy and clinical licenses as well as properly responding to patient medical grievances. In addition, the following preventive health measures scored very well:

- **100%** – Mammogram compliance for eligible women aged 50–74
- **98.18%** – Influenza vaccination offered during flu season
- **96.95%** – Clinical areas controlled exposure to blood-borne pathogens

However, this pattern contrasts with lower-performing clinical process implementation measures observed in other compliance tests. This contradiction indicates stronger cross-institution performance in administrative compliance than in operational delivery of care. Specifically, the lowest-performing compliance tests primarily involved operational aspects of health care delivery requiring real-time clinical execution, interdisciplinary coordination, and sustained workflow reliability. Deficiencies were particularly pronounced in diagnostic follow-up, emergency preparedness, medication continuity, infection control practices, and supply management, as demonstrated in Figure 4.

Figure 4. Bottom 10 Compliance Test Scores, Cycle 7



Source: OIG Medical Inspection results, www.oig.ca.gov.

In contrast to the near-perfect performance observed in administrative and documentation-based requirements, these findings suggest institutions experienced greater difficulty consistently implementing complex care delivery processes in practice.

The gap between the highest and lowest cross-institution average percentage scores in the compliance tests was dramatic:

- Highest average compliance test score across all institutions: **100%**
- Lowest average compliance test score across all institutions: **7.82%**

This 92-point spread suggests a system in which compliance is not uniformly weak but rather highly polarized; some processes strictly adhered to the HCDOM while other processes consistently revealed noncompliance across institutions. These cross-institution struggles in the lowest performing compliance tests suggest compliance failures with these policy requirements are not isolated facility problems, but rather systemic operational weaknesses concentrated in specific domains of care delivery.

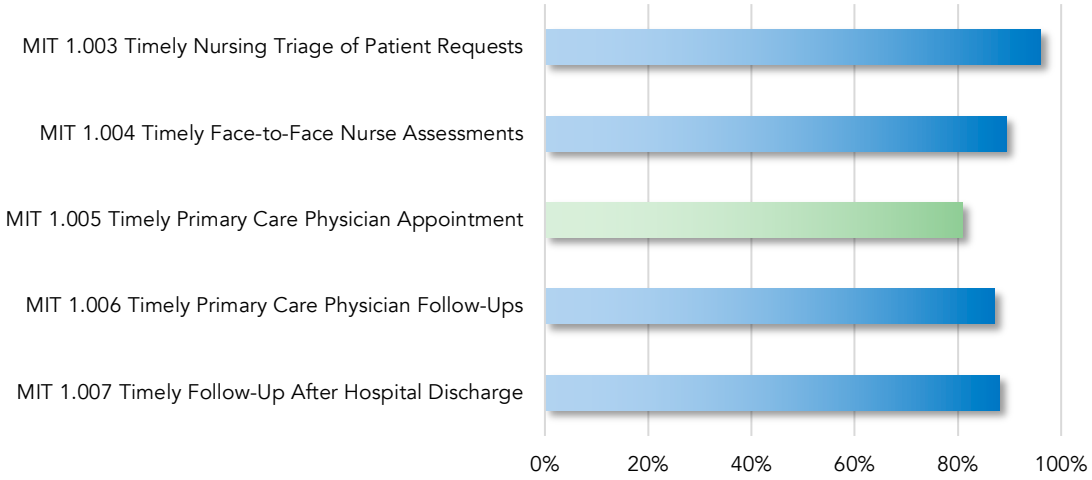
Correlations Discovered between Compliance and Case Review Inspection Findings in Cycle 7

In studying the department-wide trends in Cycle 7, we further discovered several areas in which compliance testing results paralleled case review findings. These correlations provide greater insight and clarity into cross-institution strengths and weaknesses.

Some of these correlations between compliance testing and case review findings revealed areas of excellence across the 31 institutions. For example, the Access to Care indicator, which both compliance inspectors and case review clinicians evaluate, was consistently high scoring in both components. All 31 institutions passed the case review component of this indicator, with 19 institutions achieving an ***adequate*** rating, and 12 achieving a ***proficient*** rating. Similarly, the average compliance score in this indicator among the 31 institutions was 80.7 percent, near the top of the ***adequate*** range, with seven institutions achieving ***proficient*** scores.

Interestingly, we found the extraordinarily strong performance in five of the compliance tests involving some key measures of good patient care access was echoed in the clinical quality of the patient Access to Care case review component. Figure 5 illustrates the department's high cross-institution average performance in five key compliance tests in the Access to Care indicator.

Figure 5. Compliance Tests on Patient Access to Care



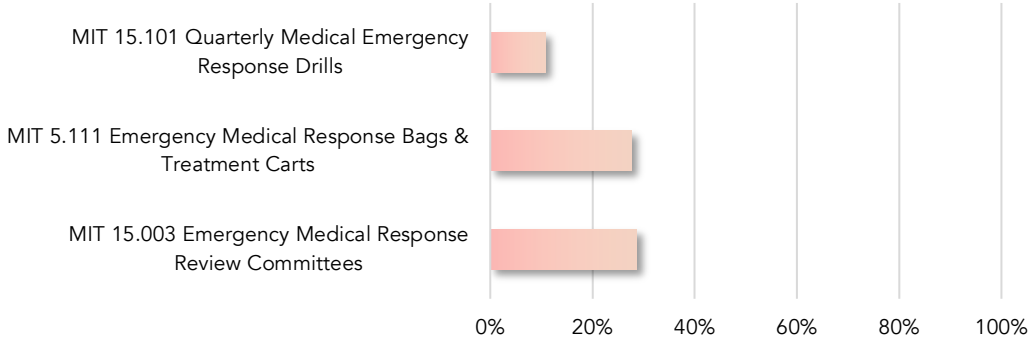
Source: OIG Medical Inspection results, www.oig.ca.gov.

Specifically, tests regarding the timeliness of nurses triaging patient care requests (MIT 1.003, average score 96.05 percent), subsequent face-to-face nurse assessments (MIT 1.004, average score 89.44 percent), subsequent primary care physician (PCP) appointments (MIT 1.005, average score 80.93 percent), PCP follow-up appointments

(MIT 1.006, average score 87.18 percent), and follow-ups after hospital discharge (MIT 1.007, average score 88.01 percent) were five of the consistently highest scoring tests, with institutions averaging within the ***proficient*** or high ***adequate*** scoring ranges. This correlation indicates the strong adherence to policy requirements positively affected the clinical quality of decision-making in this indicator.

In contrast, the poorest performing case review indicator was Emergency Services. None of the 31 institutions (zero percent) achieved a ***proficient*** rating, only 18 achieved ***adequate*** ratings, and 13 institutions ultimately received ***inadequate*** ratings for their clinical performance in the case review component of this indicator. Here again, we saw the clinical performance struggles in this indicator echoed in the related compliance tests. Figure 6 illustrates the low cross-institution average performance in three compliance tests relating to emergency preparedness and post-response review.

Figure 6. Compliance Tests on Emergency Preparation and Response Review



Source: OIG Medical Inspection results, www.oig.ca.gov.

Specifically, in Figure 6, above, tests regarding the adequacy of the institutions' quarterly emergency response drills (MIT 15.101, average score 10.75 percent), the readiness of emergency medical response bags (EMRBs) and treatment carts (MIT 5.111, average score 27.57 percent), and the adequacy of post-response emergency medical response review committee (EMRRC) incident packages (MIT 15.003, average score 28.62 percent) were three of the consistently lowest scoring tests. These emergency measures are vital to ensuring an institution's readiness to respond properly to emergency situations. This correlation suggests the weak adherence to these policy requirements negatively affected the clinical quality of decision-making in this indicator.

The poor scores across all institutions in these tests indicate these struggles are not institution specific but rather require a systemic solution. The department should undertake a department-level approach to identify the root causes of the persistently

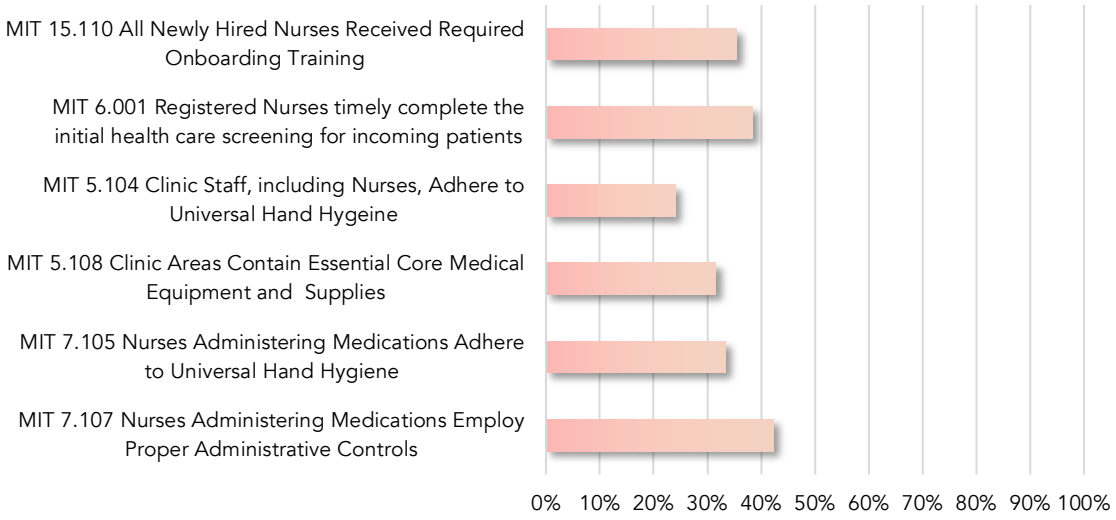
low performance across institutions in these areas. The department should update policies as needed and should develop, implement, and monitor strategies to ensure all EMRBs, treatment carts, and disaster carts remain properly stocked and monitored; health care and custody staff regularly drill on emergency responses to habitualize proper emergency protocols; and EMRRCs conduct timely and meaningful analyses of emergency responses in which they identify and correct areas needing improvement.

To aid the department in this endeavor, beginning in Cycle 8, the OIG relocated these three, and one other, compliance tests relating to emergency preparation and review, which previously existed in Indicator 5. Health Care Environment and Indicator 15. Administrative Operations, into a new compliance component for Indicator 3. Emergency Services. This will allow the OIG to better evaluate and highlight the correlation between these emergency-related compliance tests and the case review findings regarding the overall clinical quality of the institution's provision of emergency services through the next cycle.

After Emergency Services, the Nursing Performance indicator was the second poorest scoring indicator across all 31 institutions. Again, none of the institutions (zero percent) achieved a ***proficient*** rating, 22 achieved ***adequate*** ratings, and nine received ***inadequate*** ratings.

Similar to Emergency Services, we saw these nursing performance struggles mirrored in compliance tests relating to proper nurse training and attention to nursing requirement details. Figure 7 illustrates the low cross-institution average performance in six nursing-related compliance tests.

Figure 7. Compliance Tests on Nursing-Related Requirements



Source: OIG Medical Inspection results, www.oig.ca.gov.

Specifically, only 11 of 31 institutions passed our test regarding whether nurse managers ensured their newly hired nurses received the required onboarding and clinical competency training (MIT 15.110, average score 35.48 percent). Interestingly, we also found persistently low scores in tests requiring nurses to demonstrate strong attention to detail in HCDOM nursing requirements, such as tests relating to: (1) whether, for patients received from another CDCR institution, nursing staff completed the initial health screening and answered all screening questions within the required time frame (MIT 6.001, average score 38.4 percent), (2) proper sanitation and infection control (MITs 5.101–5.104, average score among four tests 55.0 percent), and (3) using proper administrative protocols in handling and administering patient medications (MITs 7.105 and 7.107, average score among two tests 37.8 percent).

These findings suggest a link between the lack of appropriate training leading to poor compliance with nursing requirements and the case review findings regarding lapses in clinical nursing judgment, decision-making, and attention to detail. The department should undertake a department-level approach to identify the root causes of persistently low performance across the institutions in ensuring proper onboarding and clinical competency training that will promote staff attention to detail and habitual adherence to these nursing HCDOM requirements. The department should implement necessary corrective measures, including updating policies as indicated. The department should further study the effects of the corrective measures implemented on the cross institution compliance with lower scoring nursing compliance test measures and amend their corrective processes as indicated.

These correlations between the persistent policy noncompliance and the lower clinical performance ratings in both the Emergency Services and Nursing Performance indicators also underscore the importance of both the case review and compliance testing components to the overall assessment of health care quality. Specifically, they provide greater insight into the potential causes for the cross-institution struggles to achieve ***adequate*** scores in the case review component in these indicators. Using Emergency Services as an example, compliance testing alone would have revealed the institutions did not comply with emergency preparation and review policies, but would not necessarily demonstrate how this non-compliance affected the clinical quality of the emergency response care. In contrast, conducting case review alone would have identified clinical judgment lapses during emergency services, but would not necessarily have identified the potential cause as lack of proper training, emergency preparedness, and post-response reviews. Both components are necessary to understand the impact of compliance lapses and identify specific areas for improvement that could positively impact the clinical quality of emergency responses.

Top Cycle 7 Recommendations Across Institutions

In addition to the cross-institution performance trends, we also studied the prevalence of their related recommendations across this cycle. This study allowed us to more clearly segregate those health care deficiencies in Cycle 7 that may be more localized to individual institutions versus those that may indicate more widespread areas of systemic proficiency or needing systemic improvements. The OIG used this analysis to enhance our inspection process for Cycle 8. We present below the six most commonly issued recommendations in Cycle 7, along with our analysis of the prevalence of each recommendation.

Hand Hygiene in Health Care Settings

The OIG issued recommendations regarding hand hygiene to 30 of 31 institutions during Cycle 7 medical inspections, indicating failure to adhere to hand-hygiene policies was systemic rather than institution specific.

CDC Guidance for Hand Hygiene in Health Care settings:

The Guideline for Hand Hygiene in Health-Care Settings provides health-care workers (HCWs) with a review of data regarding handwashing and hand antisepsis in health-care settings. In addition, it provides specific recommendations to promote improved hand-hygiene practices and reduce transmission of pathogenic microorganisms to patients and personnel in health-care settings.

Gloving Policies Section: hands should be decontaminated or washed after removing gloves.

Reference Part II. Recommendations 1. contains indications for handwashing and hand antisepsis – Part C, Part F, Part I, & Part J.

Under the Center for Disease Control (CDC) guidelines, to which HCDOM policy requires adherence, gloves are intended as an addition to, not a substitute for, hand hygiene.[4] Hands must be sanitized both before and after glove use.

Staff across institutions consistently omitted sanitization before donning gloves and immediately after removing them. Additionally, lapses often occurred during the movement between tasks and patient zones. The OIG found staff frequently failed to sanitize when entering or leaving a patient's immediate environment. Further, we found staff often sanitized after contact with the patient or their equipment had already begun, rather than prior to donning gloves at the beginning of the appointment. Cross-contamination potential existed when staff shifted between different patients, or

4. Guideline for Hand Hygiene in Health-Care Settings: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm

distinct tasks on the same patient, without remembering to deglove, sanitize hands, and don new sterile gloves.

Notably, in the few institutions in which individual staff members passed the tests associated with hand hygiene, our inspectors could readily observe the strict adherence to all hygiene protocols was habitual and automatic for those staff members, rather than actions requiring conscious policy adherence. This observation suggests a department-wide strategy to habitualize strict adherence to these hygiene requirements, such as through repetitive drills, may improve staff compliance in this area.

Patient Medications

The OIG issued recommendations regarding medications at 30 of 31 institutions during Cycle 7 medical inspections.[5] These included recommendations to improve medication continuity, particularly during hospital discharge or transfer to or from another institution, and medication documentation.

Medication Continuity: The OIG provided multiple recommendations to improve significant delays or interruptions in staff providing medications for chronic conditions, newly

Medication Continuity

- **Correctional Settings (CCR Title 15 § 3999.315):** Patients arriving from non-CDCR institutions must be seen by a provider or have medications ordered within 8 hours. Prescribers must renew orders specifically to "facilitate medication continuity".

Discharge & Transfer Delays

- **Discharge Procedures (CCR Title 22 § 97520.11):** Written procedures must ensure medical records are checked, discharge instructions are complete, and patients are advised on the proper use and storage of prescribed drugs.
- **Providing Medications (CCR Title 22 § 73369 & § 785.28):** Drugs may be sent with a patient upon discharge if ordered by the physician, and this must be recorded in the health record.

Documentation Failures

- **Nursing Requirements (CCR Title 22 § 73313):** The person who administers the drug must properly record the time and dose in the patient's medication record.
- **General Administration (CCR Title 22 § 79215):** As evidence of administration, health records must contain the drug name, dosage, time, and the name or initial of the person who gave it.
- **Documentation Standards (CCR Title 22 § 81075 & § 87919):** Records for centrally stored medications must include the resident's name, physician, drug name, strength, quantity, date filled, and prescription number.

5. HCDOM References: Medication Availability: Ch. 3. Article 5 3.5.8.(e)(14)(B).1-2: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-5-pharmacy/3-5-8-prescription-order-requirements-and-medication-availability/
Medication Administration Lines – General Population: Ch.3 Article 5 3.5.29.(c)(3)(E)1-3: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-5-pharmacy/3-5-29-medication-administration/
Medication No-Shows for Medication Lines (Medication Administration): Ch. 3 Article 5 3.5.30.(c)(4)(B)1-3: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-5-pharmacy/3-5-30-medication-adherence/

ordered medications, and medications for patients returning from hospitals or off-site specialty appointments.

Discharge and Transfer Delays:
Several medication continuity recommendations focused specifically on improvements for staff providing medications timely for patients who discharged from a higher level of care or who transferred to or from another institution.

Documentation Failures: The OIG also provided multiple recommendations to improve staff accuracy when recording medication administration in the electronic health records system (EHRS) and the medication administration record (MAR).

The prevalence of errors relating to patient medication processes again indicates the struggles with strict policy adherence in this area is systemic, rather than institution specific. This suggests the department should undertake analysis at the department level to determine the root causes for medication distribution noncompliance; should update their policies as needed; and should develop, implement, and monitor strategies to habitualize strict policy adherence in staff across all institutions.

Diagnostic Test Result Patient Notification Letters

The OIG issued recommendations regarding untimely or incomplete patient letters at 30 of 31 institutions during Cycle 7 medical inspections.

Policy requires providers to create and issue letters educating patients about the results of their diagnostic tests at the same time the provider endorses (meaning approves or signs off for) those diagnostic test results.[6]

September 2025 CCHCS HC DOM Ch. 3 Article 1 3.1.13.c.6.A.1;
Provider Review of Imaging Studies Results and Patient Notification and Follow-up

A. Following the finalization of all imaging studies as described in Sections (c)(3) through (5) above, the health care provider shall:

1. Review and endorse the report within five calendar days of receiving an examination report notification into the Electronic Health Records System (EHRS).
2. Create a patient notification letter in the EHRS at the time of the provider's review of the examination results. The patient notification letters shall include the following:
   a. Date of the examination results.
   b. Name of the health care provider who reviewed and endorsed the medical imaging result.
   c. The clinical significance or meaning of the medical imaging results such as, but not limited to, whether the results are unchanged, or within normal limits, or as expected, or whether additional testing is required.
   d. Whether a follow-up appointment with the provider is required and that it will be scheduled.

B. Patient notification letters shall be printed for collection by the designated staff member to be distributed to the patients.

6. California Code of Regulations, Title 22, Division 5, Chapter 9, Article 4, Section 77139, Health Record Service; Section 77141, Health Record Content; and Section 77143, Health Record Availability; Patient Health Care Inquiry Response (15 CCR § 3999.218); Scheduling and Access to Care (15 CCR § 3999.303); Health Care Grievance Process (15 CCR § 3999.227): https://www.dir.ca.gov/dlse/ccr.htm

The OIG frequently offered recommendations to correct significant delays between the time a provider endorsed a diagnostic test result and the time the provider issued the test result notification letter to the patient. The OIG also issued multiple recommendations to correct erroneously omitted patient notification letters as well as to ensure these patient letters contained all required elements mandated by policy (see policy, above).[7]

During Cycle 7, the creation and issuance of these letters were manual, meaning these letters did not automatically generate upon provider endorsement and populate accurately, instead requiring providers to consciously remember to create the letter and manually include the four required elements to meet result notification requirements. However, the frequency of these recommendations indicates this lack of automation increased the risk of error. We understand the department has begun developing and implementing a systemic strategy to automate this process, which we anticipate will significantly increase cross-institution compliance in this area.

Medical Supplies

The OIG issued recommendations regarding medical supply management and control at 28 of 31 institutions during Cycle 7 in response to finding that staff did not consistently follow protocols for managing medical equipment and supplies.

The OIG offered multiple recommendations to correct clinic examination rooms missing essential core equipment and inadequately stocked storage areas. The OIG further offered frequent recommendations to correct improper storage of medical supplies both inside and

CCR Title 22 § 78439(a): Mandates that equipment and supplies must be maintained in adequate quality and quantity for patient care.

CCR Title 22 § 79835: Storage and Organization Standards require that clean and soiled materials are kept separate to prevent contamination.

CCR Title 22 § 79835(b), (e), (f): Requires dedicated, equipped, and staffed areas for storing sterile materials, along with proper separation from contaminated items and an orderly, rotated storage.

January 2024 CCHCS HCDOM Ch. 3 Article 7 3.7.1-1. d:

(14) Required equipment and supplies are always readily accessible in the institution to health care staff in the TTA, clinical areas, EMRVs, and other areas as deemed appropriate by the CEO and the Warden.
(15) A process is in place to document that required inventories and maintenance have been performed. Procedures shall ensure that the required documentation is retained for one year, audited monthly, and reviewed as part of the institution's EMRS quality improvement process system.

7. HCDOM References: Radiology: Ch. 3 Article 1. 3.1.13.c.6.A.2: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-1-complete-care-model/3-1-13-medical-imaging-services/; Laboratory: Ch.3 Article 1 3.1.14.c.4.E: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-1-complete-care-model/3-1-14-laboratory-services/; Pathology: Ch. 3 Article 1 3.1.14 Appendix 3: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-1-complete-care-model/

outside of clinic areas, indicating staff systemically failed to conduct equipment checks and inventory supplies.[8]

The OIG's repeated recommendations about proper medical supply control and storage suggests the department should conduct a department-wide analysis to identify whether the root causes of these breakdowns across all institutions are due to a lack of training, poor storage layouts, unclear protocols, or other causes. Department leadership should update policies as needed and develop, implement, and monitor department-wide strategies to address and correct the identified causes.[9]

Patient Care Access in Less Common Circumstances

While, as previously noted, access to common patient care was generally ***proficient*** across all institutions in Cycle 7, the OIG issued recommendations regarding the inadequate scheduling of less common patient appointments at 28 of 31 institutions during Cycle 7 medical inspections.

California Code of Regulations (CCR)
Scheduling and Access to Care: CCR Title 15, § 3999.303, mandates an efficient scheduling system for timely access.

- **Routine Primary Care Physician (PCP) Referrals:** Must be seen within **14 calendar days**.
- **Urgent Referrals:** Must be seen within **24 hours**.

Specialty Services: The Prison Health Care Provider Network Operations Manual oversees the process for specialty medical services, including cardiology, surgery, and procedures like colonoscopies.

HCDOM References:
For general access to care
Ch 3, Article 1, section 3.1.5.c.2.B contains the relevant requirements for scheduling and access to care, including timing of encounters after requests for services and determination of urgency of requests.

For patient follow-up appointments
Ch 3, Article 1, section 3.1.9(c)(3)(F)(10) requires that patients discharged to an outpatient setting from a community hospital, emergency department, or any non-mental health CDCR health care bed shall be seen by their PCP within five calendar days of discharge.

Ch. 3, Article 1, 3.1.11.(c)(7)(B) & (C) requires the PCP to see the patient within 5 calendar days of a high priority specialty appointment.

The OIG offered frequent recommendations to correct delays in timely providing specialty appointments, particularly for high-priority referrals, chronic care, and prenatal/obstetric services. OIG recommendations also frequently focused on failures to ensure follow-up appointments occur after specialty encounters, emergency room encounters, or hospital discharges within required timeframes. We further offered multiple

8. California Code of Regulations (CCR): https://www.dir.ca.gov/dlse/ccr.htm
9. HCDOM Reference: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-6-durable-medical-equipment-supplies-and-accommodations/3-6-1-durable-medical-equipment-and-medical-supply/

recommendations to improve incomplete patient screenings and documentation of pending specialty care for patients transferring between institutions.[10]

The prevalence of these recommendations again indicates these struggles are not institution specific but rather require a systemic solution. The department should undertake a department-level analysis to identify the root causes of the consistent noncompliance in these less common areas of patient access to care.[11] For example, the department may wish to investigate the workflow and communication logistics to identify the disconnects that result in chronic or follow-up appointment scheduling delays; failure to communicate specialty results to primary care teams; and failure to ensure care continuity during transfers, specialty returns, and hospital discharge returns. The department should update policies as needed and should develop, implement, and monitor strategies to address and correct these issues.

Patient Nursing Assessments and Documentation

The OIG issued recommendations regarding insufficient or untimely patient assessments in 27 of 31 institutions during Cycle 7 medical inspections.

The OIG offered multiple recommendations to improve nursing performance in conducting thorough patient assessments across various settings (emergencies, specialized housing, and clinics). Many of these recommendations focused on ensuring nurses timely and

HCDOM Reference:
Patient Care/Coordination
Ch. 3. Article 1 3.1.11(c)(7)(E)

(E) At the follow-up appointment, the PCP or dentist shall discuss the specialty provider's findings and recommendations with the patient, as clinically appropriate, and document the discussion in the health record.

1. Ongoing treatments such as dialysis, chemotherapy, radiation therapy, pacemaker interrogations, and related follow-ups require only an initial approval to initiate the series of treatments and consultations.
2. If the specialty provider recommends a new procedure, surgery, or specialist consultation, and the PCP or dentist agrees with the specialty provider's recommendations, a new RFS shall be submitted.
3. Follow-up with the specialty provider after a procedure or surgery does not require another RFS order if completed within the global surgery schedule time frames.
4. All other specialty follow-up services occurring 12 months after the date of the original RFS order require a new RFS order.

10. California Code of Regulations (CCR): https://www.dir.ca.gov/dlse/ccr.htm
11. HCDOM Reference: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-1-complete-care-model/3-1-5-scheduling-and-access-to-care-3-2-2/; https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-1-complete-care-model/3-1-5-scheduling-and-access-to-care-3-2-2/; https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-1-complete-care-model/3-1-9-health-care-transfer/; https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-1-complete-care-model/3-1-11-outpatient-specialty-services/. See also California Code of Regulations (CCR) – 22 CCR 80069, 22 CCR 70211, 22 CCR 70701.

accurately recorded critical patient information, including vitals and follow-up care plans. Other recommendations focused on ensuring timely notification to providers regarding abnormal findings and correcting failures to properly document specialty appointment results.

Interestingly, the deficiencies for insufficient nursing assessments spanned a wide variety of causes.[12] Assessment deficiencies included skills that require significant clinical competency, such as complex wound care or PICC line maintenance; interventions that require maintaining presence of mind in high stress situations, such as in urgent and emergency circumstances; and tasks requiring significant attention to detail, such as completing all aspects of a full head-to-toe assessment and thoroughly documenting each finding. As noted above in the section on Cycle 7 case review and compliance correlations, many of these nursing deficiencies may relate to the consistent cross-institution struggle to ensure new nurses receive required onboarding and competency training. In emergency responses, some of these deficiencies may also relate to the lack of proper equipment from improperly stocked EMRBs and treatment carts as well as insufficient hands-on training drills involving both custody and health care staff.

The frequency and variance of these assessment errors across so many institutions indicate the department should undertake department-level analysis to identify the root causes for each variation of these deficiencies.[13] The department should update policies as needed to clarify expectations and processes, and department leadership should develop, implement, and monitor strategies across all institutions to ensure health care staff, particularly nurses, receive all necessary skill trainings; engage in high-stress circumstance response drills; properly stock all medical supplies, particularly for emergency responses; and habitualize attention to detail.

12. California Code of Regulations (CCR): https://www.dir.ca.gov/dlse/ccr.htm
13. Outpatient Specialty Services: https://www.cdcr.ca.gov/hcdom/dom/chapter-3-health-care-operations/article-1-complete-care-model/3-1-11-outpatient-specialty-services/

Conclusion

Overall, the analysis of the cross-institution performance trends we identified during our seventh cycle of medical inspections indicates strong policy adherence in administrative health care requirements, but a need for systemic improvement in staff compliance with operational implementation of daily patient care. However, our analysis also highlighted the consistently passing performance in the case review component across most institutions and the cross-cycle trends displaying consistent and sustained systemic improvement in the quality of clinical care over the past three cycles. The strong case review scores indicate these areas of systemic noncompliance are generally not negatively impacting the quality of clinical judgment and decision-making patients receive in these institutions, except as noted in the Emergency Services and Nursing Performance indicators.

The OIG used this analysis in part to enhance our inspection process for Cycle 8. Specifically, as noted above, our new testing methodologies provide greater focus on emergency response testing, and we further amended our inspection processes to promote greater inspection accuracy, as agreed by our stakeholders during meetings we held prior to initiating Cycle 8.

We appreciate the opportunity to evaluate institution performance through our Cycle 7 inspection process, allowing us to assess the institution's medical care on both individual and system levels. We hope this report will provide a meaningful analysis of how the department can continue in its efforts to continually improve health care for California's incarcerated patient population. We look forward to continuing our work in partnership with our stakeholders to ensure the ongoing health care provided meets or exceeds both general correctional and community health care standards as well as the specific health regulations and policies governing the department, codified in Titles 15 and 22 of the California Code of Regulations and the department's HCDOM.

Summary and Trend Analysis of the OIG's Seventh Cycle of Medical Inspections

November 2022 – April 2026

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STATE *of* CALIFORNIA
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