Roy W. Wesley, *Inspector General*

Bryan B. Beyer, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

September 2020

Cycle 6
Medical Inspection Report

California Correctional Center

Electronic copies of reports published by the Office of the Inspector General are available free in portable document format (PDF) on our website.

We also offer an online subscription service.
For information on how to subscribe,
visit **www.oig.ca.gov**.

For questions concerning the contents of this report,
please contact Shaun Spillane, Public Information Officer,
at 916-255-1131.

Contents

Illustrations

Tables

Figures

Photographs

Cover: Rod of Asclepius courtesy of Thomas Shafee

Introduction

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

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[2]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[3] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[4] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

1. 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.

2. 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.

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

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

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

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

We completed our sixth inspection of CCC, and this report presents our assessment of the health care provided at that institution during the inspection period between March 2019 and September 2019.[5] Notably, our report of CCC was not impacted by the novel coronavirus disease pandemic (COVID-19). The data we obtained for CCC predates COVID-19, so neither case review nor compliance testing were affected. Similarly, the on-site regional nurse review was not impacted by COVID-19.

CCC is located in Susanville, in Lassen County. It is designated as a *basic care institution*, which houses healthier, minimum-custody patients, and it is located in a rural area, away from tertiary care centers and specialty care services. CCC provides general outpatient health care services in its clinics, urgent or emergency care in its triage and treatment area (TTA), and inpatient health services in its correctional treatment center (OHU).

5. Samples are obtained per the case review methodology shared with stakeholders in prior cycles. The case review samples include emergency reviews that occurred between November 2018 and September 2019, CPR reviews that occurred between November 2018 and May 2019; death reviews that occurred between January 2019 and April 2019; diabetes reviews that occurred between February 2019 and September 2019, high-risk reviews that occurred between December 2018 and September 2019; and RN sick call reviews that occurred between January 2019 and September 2019.

Summary

We completed the Cycle 6 inspection of California Correctional Center (CCC) in November 2019. OIG inspectors monitored the institution's delivery of medical care that occurred between March 2019 and September 2019.

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

Table 1. CCC Summary Table

Ratings

Proficient *Adequate* *Inadequate*

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

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

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

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

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 346 patient records and 1,011 data points and observed CCC's processes during an on-site inspection in August 2019 Month 20xx. They used the data to answer 89 policy questions. Table 2 below lists CCC's average scores from Cycles 4, 5, and 6.

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 49 cases, which contained 580 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in November 2019 to verify their initial findings. Of the 580 individual health care events, the OIG clinicians identified

Table 2. CCC Policy Compliance Scores

Scoring Ranges

100%–85% | 84%–75% | 74%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	82%	75%	90%
2	Diagnostic Services	79%	77%	39%
4	Health Information Management	60%	77%	87%
5	Health Care Environment	53%	74%	67%
6	Transfers	65%	73%	75%
7	Medication Management	89%	72%	67%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	81%	72%	68%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	92%	67%	87%
14	Specialty Services	80%	80%	84%
15	Administrative Operations	77%	84%	86%

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

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

110 deficiencies. However, only 19 of these deficiencies were of such a magnitude that our clinicians felt they resulted in potential significant risk of harm to patients.

The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our clinicians rated 16 ***adequate*** and four ***inadequate***. Our clinicians found no adverse events during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[6] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes which may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the CCC Summary Table.

In April 2019, the Health Care Services Master Registry showed that CCC had a total population of 3,961. A breakdown of the medical risk level of the CCC population as determined by the department is set forth in Table 3 below.

Table 3. CCC Master Registry Data as of August 2019

Medical Risk Level	Number of Patients	Percentage
High 1	2	0.1%
High 2	19	0.5%
Medium	283	7.1%
Low	3,657	92.3%
Total	**3,961**	**100.0%**

Source: Cycle 6 medical inspection preinspection questionnaire staffing matrix received on August 12, 2019, from California Correctional Center.

6. The indicators for **Reception Center** and **Prenatal Care** do not apply to CCC.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, CCC had two and one-half vacant primary care provider positions and five vacant nurse positions. At the time of the OIG's on-site inspection, one nursing supervisor and eight nursing staff were on extended leave from the institution.

Table 4. CCC Health Care Staffing Resources as of August 2019

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5	6.5	9.5	51.9	72.9
Filled by Civil Service	4	4	9.5	47	64.5
Vacant	10	2.5	0	4.9	8.4
Percentage Filled by Civil Service	80%	62%	100%	91%	88%
Filled by Telemedicine	1	3	0	0	4
Percentage Filled by Telemedicine	20%	46%	0	0	0
Filled by Registry	0	1	0	3	4
Percentage Filled by Registry	0	15%	0	4%	5%
Total Filled Positions	4	6	9.5	50	69.5
Total Percentage Filled	80%	92%	100%	96%	95%
Appointments in Last 12 Months	0	1	2	3	6
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	1	8	9
Adjusted Total: Filled Positions	4	6	8.5	42	60.5
Adjusted Total: Percentage Filled	**80%**	**90%**	**89%**	**81%**	**83%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

Note: The OIG does not independently validate staffing data received from the department.

Source: Cycle 6 medical inspection preinspection questionnaire staffing matrix received on August 12, 2019, from California Correctional Center.

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.[7]

Our inspectors did not find any adverse events at CCC during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to CCC. Of these 10 indicators, OIG clinicians rated two ***proficient***, seven ***adequate***, and one ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 16 were ***adequate*** and four were ***inadequate***. In the 580 events reviewed, there were 110 deficiencies, 19 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 CCC:

- Since we completed our review during Cycle 5 , CCC continued to provide timely and appropriate specialty services to patients.
- CCC continued to use telemedicine for both primary care providers and specialists to enhance the delivery of medical care at its remote location.
- The institution performed well in providing timely patient access to primary care providers and nurses.
- CCC nursing leadership remained committed to improving the quality of nursing care through continual nursing education and training.

Our clinicians found CCC could improve in the following areas:

- At the time of our inspection, CCC continued to lack a regular on-site medical supervisor. The telemedicine chief physician and surgeon (CP&S) had just been promoted to chief medical executive (CME) and continued providing leadership primarily

7. For a further discussion of an adverse event, see Table A–1.

through telemedicine. As a result, the CP&S position was vacant. Although we acknowledge the new CME continued to provide excellent leadership and guidance, the institution would also have benefited from a CP&S who was regularly on-site to further support the telemedicine CME.

- There were lapses in continuity of care for camp patients returning from the hospital emergency department.
- During transfers, there were lapses in care when CCC nurses did not provide pertinent information, such as pending specialty orders.
- Nursing staff did not always document their emergency care completely and accurately.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to CCC. Of these 10 indicators, our compliance inspectors rated four ***proficient***, two ***adequate***, and four ***inadequate***. In the **Health Care Environment**, **Preventive Services**, and **Administrative Operations** indicators, we tested policy compliance only, because how the institution performed in these indicators usually does not significantly affect the institution's overall quality of patient care.

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

- CCC excelled in providing timely appointments for chronic care patients, patients returning from hospital admission, and patients returning from specialty services. Moreover, patients were referred within required time frames to their providers upon arrival at the institution.
- Nursing staff processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames.
- The institution completed high-priority, medium-priority, and routine specialty services within required time frames.

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

- CCC providers often communicated diagnostic results late, and when communicating test results, sent patient letters that were missing key elements required by CCHCS policy.
- Patients often did not receive their chronic care medications within required time frames. There was also poor medication continuity for patients who were admitted to CCC's specialized medical housing unit.
- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.

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 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores, but the OIG obtained Kaiser Medi-Cal HEDIS scores through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report* to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered CCC's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. CCC's results compared favorably with those found in State health plans for diabetic care measures. We list the five HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs (California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)), CCC performed better in all five of the diabetic measures.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. CCC had a 37 percent immunization rate for adults, due to a high number of patient refusals among the adult population.[8] The immunization rate for older adults was 67 percent. The pneumococcal vaccine rate was 100 percent.

Cancer Screening

For colorectal cancer screening, CCC had an 89 percent screening rate. Statewide comparative data were not available for cancer screening; however, we include this data for informational purposes.

8. The Institution reported a 63 percent refusal rate for immunizations among the adult population.

Table 5. CCC Results Compared With State HEDIS Scores

HEDIS Measure	CCC Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**100%**	87%	95%	95%
Poor HbA1c Control (>9.0%)‡,§	**8%**	35%	24%	19%
HbA1c Control (<8.0%)‡	**83%**	54%	63%	71%
Blood Pressure Control (<140/90)‡	**92%**	66%	76%	85%
Eye Examinations	**87%**	61%	75%	84%
Influenza–Adults (18–64)	**71%**	–	–	–
Influenza–Adults (65+)	**97%**	–	–	–
Pneumococcal–Adults (65+)	**90%**	–	–	–
Colorectal Cancer Screening	**93%**	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in June 2019 by reviewing medical records from a sample of CCC's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled, *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2017–June 30, 2018 (published April 2019).

‡ For this indicator, the entire applicable CCC 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 obtained from the CCHCS Master Registry.

Recommendations

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

- Medical leadership should remind providers to send patient notification letters for pathology and laboratory results within required time frames.
- Medical leadership should review laboratory processes to ensure laboratory test are completed within required time frames.
- Health information management supervisors should implement processes to obtain pathology reports within required time frames.
- Nursing leadership should remind first responders and nursing staff to document emergency events thoroughly, accurately, and consistently.
- Medical leadership should remind providers to review specialty reports within required time frames.
- Medical leadership should remind providers to review pathology results and communicate these results to the patient within required time frames.
- Medical leadership should ensure that staff follow management protocols, such as not storing cleaning supplies in the same area with medical supplies, not storing food in the medical supply storage room, identifying all medical supplies, ensuring sterile medical supply packaging, and removing all expired medical supplies.
- Medical leadership should ensure adequate medical supply storage.
- Medical leadership should ensure appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations.
- Health care staff should consistently follow universal hand hygiene precautions during patient encounters.
- Nursing leadership to remind receiving and release (R&R) nurses to properly complete initial intake assessments.

- Medical leadership should review policies for camp patients returning from the hospital emergency department to ensure proper continuity of care.
- Nursing leadership should remind nurses to provide pertinent information, such as pending specialty orders, during transfers to avoid lapses in care.
- Medical and pharmacy leadership should ensure that chronic care, hospital discharged, and specialized medical housing patients receive their medications within required time frames.
- Nursing leadership should remind nursing staff to follow hand hygiene contamination control protocols during medication preparation and medication administration.
- Nursing leadership should remind nurses to fully document tuberculosis (TB) symptoms for monitoring.
- Nursing leadership should remind nurses to thoroughly review patients' medical records and perform complete assessments.
- Medical leadership should remind providers to review and use published CCHCS care guidelines for diabetes.
- Providers should perform an admission history and physicals examination within the required time frame.
- Medical leadership should review specialty report retrieval requirements with staff and ensure providers review specialty reports within required time frames.
- The Emergency Medical Response Review Committee (EMRRC) should review emergency medical response incidents at the regular monthly meeting following the date of the incidents, as required by policy.

Access to Care

In this indicator, OIG inspectors evaluated the institution's provision of timely clinical appointments. We reviewed the scheduling and appointment timeliness for newly arrived patients' appointments, sick call appointments, and nurse follow-up appointments, and we examined referrals to primary care providers and specialists. We also evaluated the follow-up appointments for patients who received specialty care or returned from an off-site hospitalization.

Overall Rating
Proficient

Case Review Rating
Proficient

Compliance Score
Proficient **(90%)**

Results Overview

Since our Cycle 5 review, CCC has improved its ability to provide patients with access to care despite the institution's geographical limitation. During the present review, the institution had a minimal patient backlog, which included patients who were at off-site fire camps. The institution continued to perform well in provider-ordered follow-up appointments, Outpatient Housing Unit (OHU) follow-ups, and RN-to-provider referrals. The institution scored high overall in compliance testing. On the whole, we rated this indicator ***proficient***.

Case Review Results

We reviewed 299 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified four deficiencies relating to **Access to Care**, two of which were significant.[9]

Access to Clinic Providers

Since our Cycle 5 review, CCC has improved access to providers for routine and follow-up appointments. Failure to ensure availability with provider appointments can cause lapses in care. We reviewed 123 outpatient provider encounters and identified only one deficiency (albeit severe). The case synopsis follows:

- In case 1, the patient had a history of severe sleep apnea. He was transferred to CCC and provider follow-up was not ordered. The institution did not ensure the appropriate follow-up for the patient's sleep apnea.

Compliance testing demonstrated excellent access overall for the outpatient encounters. Chronic care follow-up appointments occurred in 88 percent of the cases tested (MIT 1.001). Nurse referrals for provider evaluations occurred in 93 percent of the cases tested (MIT 1.005). Episodic follow-up appointments occurred in all of the cases tested (MIT 1.006, 100%).

9. Minor deficiencies occurred in cases 1, 23, 29, and 49. Significant deficiencies occurred in cases 1 and 29.

Access to Specialized Medical Housing Providers

The institution performed superbly with access in specialized medical housing. We reviewed three Outpatient Housing Unit (OHU) admissions with 18 provider encounters. Case review found no deficiencies in provider follow-ups in the OHU. This result was also reflected in the compliance testing, which showed all provider follow-ups in the OHU occurred within the required time frame (MIT 13.003, 100%). However, compliance testing revealed written history and physical examinations were completed within the required time frame in only two of the three samples we were able to test during this inspection (MIT 13.002, 67%).

Access to Clinic Nurses

RN sick call access was very good. We did not find any delays in the review of sick call requests or in RN face-to-face encounters. Our compliance testing result corroborated our case review finding on the same-day triage of patient sick call requests (MIT 1.003, 100%). For RN face-to-face visits within one business day, our testing showed good compliance (MIT 1.004, 80%). Of the 30 patients' appointments we tested, three of the RN appointments did not occur within required time frames and another three did not meet the documentation requirements.

Provider-to-nurse referrals and care coordinator appointments also occurred within required time frames. We found only one instance wherein the clinic nurse appointment was not scheduled correctly.[10]

Access to Specialty Services

The institution performed well in access to initial specialty services for high-priority (MIT 14.001, 87%), medium-priority (MIT 14.004, 93%), and routine referrals (MIT 14.007, 100%). However, subsequent follow-up to a high-priority specialty service appointment occurred only in three of the four samples tested (MIT 14.003, 75%). CCC performed well in the subsequent follow-ups to a medium-priority and routine priority specialty service appointments as ordered by the provider (MIT 14.006, 100% and MIT 14.009, 100%). Case review did not identify any deficiencies in the access of specialty services.

Provider Follow-up After Specialty Service

CCC consistently provided patients with a provider follow-up after specialty services. We examined 41 diagnostic and consultative specialty services and did not find any instances in which a provider follow-up was delayed. Our compliance review yielded similar results, finding 90 percent (MIT 1.008) of the provider follow-ups occurred within required time frames after specialty services.

10. The minor deficiency occurred in case 49.

Follow-up After Hospitalization

The institution generally ensured their patients had follow-up with their providers after returning from an outside hospital. Case reviews identified only one deficiency wherein follow-up did not occur within required time frames and compliance testing found all discharged patients had a punctual follow-up appointment with their providers (MIT 1.007, 100%).

Follow-up After Urgent or Emergent Care (TTA or SEMS)

The institution ensured timely provider follow-ups after patients returned from the triage and treatment area (TTA). We reviewed 19 TTA encounters, of which six required a provider follow-up. All appointments occurred within the required time frames.

Follow-up After Transferring Into the Institution

CCC performed well in patient follow-up after the patient transferred into the institution. The compliance score for the initial health screening by a clinician was 88 percent (MIT 1.002). We reviewed 10 transfers to CCC and found only one significant deficiency, which we discuss in the **Transfers** indicator section.

Clinician On-Site Inspection

CCC staff provide medical care both by on-site providers and by telemedicine providers. These staff provide care to CCC inmates as well as to inmates in several fire camps. At the time of our Cycle 6 on-site inspection, CCC housed approximately 2,400 patients in the main facility and approximately 1,370 patients at fire camps. Fire camps usually house young patients, most of whom are low medical risk and are able to assist in fighting fires.

During our Cycle 5 review, we noted that the distant locations of the fire camps posed a challenge to providing access to care. At that time, there were patient backlogs at those camps because patients were not seen during the fire season, which usually runs from May through August.

Since then, CCC has improved access to care for these patients. The institution facilitated access to care for fire camp patients during the May-through-August fire season by bringing them back to the main facility for their scheduled appointments; CCC also provided telemedicine clinics for the fire camp sites. As a result, the institution had a backlog of only two off-site fire camp patients during the Cycle 6 inspection.

During Cycle 6 on-site interviews, staff informed us that each yard had a telemedicine provider. During this on-site inspection, Yards A and C had no patient backlog and Yard B had only a two-patient backlog.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Access to Care**, we offer no recommendations to the department.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	22	3	0	88%
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	3	0	88%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	24	6	0	80%
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) *	13	1	16	93%
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) *	8	0	22	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) *	4	0	0	100%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	35	4	6	90%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	4	2	0	67%
				Overall percentage (MIT 1): 90%

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

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

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

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	2	1	7	67%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	7	0	3	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) *	13	2	0	87%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	3	1	11	75%
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) *	14	1	0	93%
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	0	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) *	15	0	0	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) *	8	0	7	100%

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

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

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

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in completing radiology, laboratory, and pathology tests within required time frames. We determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. We also examined the staff's prompt completion and review of stat (immediate) laboratory tests.

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (39%)**

Results Overview

Our compliance testing and case reviews produced different ratings for this indicator. In compliance testing, CCC scored low in completing lab tests within require time frames. Compliance testing also showed that providers often did not notify patients of their laboratory or radiology results within required time frames, staff did not retrieve pathology reports within required time frames, and providers did not review pathology reports within required time frames. Radiology test completion and providers' review of radiology tests scored higher. In contrast, case reviewers found better performance with health information management and diagnostic test completion. Factoring together both compliance testing and case review results, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 114 diagnostic events and found three minor deficiencies, none of which were significant. All three deficiencies concerned the completion of diagnostic tests.[11] In health information management, we considered test reports that were never retrieved or reviewed to be a problem as severe as tests that were not performed.

Test Completion

Since our Cycle 5 review, CCC has continued to perform poorly in completing laboratory tests within required time frames (MIT 2.004, 30%). Case review also found diagnostic tests performed outside of the requested time frames in three of nineteen cases that included diagnostic events. There were no stat laboratory tests available for case review or for compliance testing during this review period.

Regarding radiology services, which includes completed X-rays, ultrasounds, CT scans, and MRI scans, the institution continued to perform well. Our compliance testing showed radiology services were provided within the required time frame in 80 percent of the samples tested (MIT 2.001). Case reviews further supported this finding.

11. Minor deficiencies occurred in cases 4, 12, and 19.

Health Information

Our compliance testing found CCC received a final pathology report within the required time frame for only one of the six samples we were able to test during this inspection (MIT 2.010, 17%). Similarly, providers reviewed and endorsed a pathology report within the specified time frames in only one of the four samples tested during this inspection (MIT 2.011, 25%).

In contrast, our compliance testing revealed CCC providers did very well in signing diagnostic reports. Providers promptly signed radiology reports (MIT 2.002, 100%) and laboratory reports (MIT 2.005, 90%). We reviewed no stat laboratory results during this review period. Our case reviewers did not find any deficiencies with health information management of diagnostic information.

Clinician On-Site Inspection

During the Cycle 5 inspection, the institution demonstrated poor performance in retrieving and scanning radiology reports. Since that inspection, CCC has been scanning radiology reports into the electronic health record system (EHRS). Providers can access radiology information either through EHRS or through the radiology information systems and picture archiving and communication system (RIS–PACS). This allowed the providers to have two methods of accessing radiology reports with EHRS and RIS–PACS.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Diagnostic Services**, we offer the following recommendations to the department:

- Medical leadership should remind providers to send patient notification letters for pathology and laboratory results within required time frames.
- Medical leadership should review laboratory processes to ensure laboratory tests are completed within required time frames.
- Health information management supervisors should implement processes to obtain pathology reports within required time frames.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	8	2	0	80%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	1	9	0	10%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	3	7	0	30%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	N/A	N/A	N/A	N/A
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	1	5	0	17%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	1	3	2	25%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	4	2	0
				Overall percentage (MIT 2): 39%

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Emergency Services

In this indicator, OIG evaluated the quality of emergency medical care by assessing 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. We also evaluated the Emergency Medical Response Review Committee's (EMRRC) performance in identifying problems with its emergency services. We assessed the institution's emergency services through case review only; we performed no compliance testing for this indicator.

Results Overview

CCC staff promptly responded to medical emergencies and performed life-saving measures within required time frames. CCC providers and nurses generally performed well and provided good care. Although we identified opportunities for improvement in nursing assessment and documentation in the emergency medical response, these problems were not widespread. Overall, we rated this indicator ***adequate***.

Case Review Results

We reviewed 19 urgent or emergent events and found 15 emergency care deficiencies.[12] Three of these deficiencies were significant.[13]

Emergency Medical Response

CCC staff responded promptly to medical emergencies. Our clinicians reviewed eight cases that required first medical responders at the scene and did not find any delays in response. We identified one case that required CPR, which staff initiated immediately, but staff delayed in contacting 9-1-1.[14]

Provider Performance

The TTA providers provided excellent emergency care. We did not find any deficiencies in their assessments and clinical decisions.

Nursing Performance

CCC nurses responded to medical emergencies without delay. Nursing assessments and emergency care were generally sufficient. However, nurses contributed to the delay in medical care in these cases:

12. Deficiencies occurred in cases 1, 3, 4, 5, 6, 7, 9, 19, 20, and 24.
13. Significant deficiencies occurred in cases 9 and 24.
14. This deficiency occurred in case 1.

- In case 1, the first medical responders did not instruct the staff to call 9-1-1 upon arrival at the scene. The nurse contacted 9-1-1 seven minutes after the patient was found unresponsive. The nurse did not follow clinical protocol.
- In case 9, the first medical responder did not properly examine the patient, who sustained face and head injuries from a fight. Another nurse evaluated the same patient 30 minutes later and allowed the patient to walk to the TTA. The nurse did not conduct a complete assessment; this fell below the nursing standard of care.
- In case 24, the TTA nurse was informed of the patient's injuries (swollen wrists) and did not evaluate the patient. The nurse's lack of assessment was a serious lapse in nursing standards.

Nursing Documentation

Our clinicians found several opportunities for improvement in emergency care documentation. In the cases we reviewed, nursing documentation lacked thoroughness, accuracy, or consistency among documents. Examples of these documentation deficiencies included incomplete entries regarding the care provided to the patient, inaccurate description of the emergency event, and inconsistent recording of timelines.[15] In two cases , the first medical responders did not complete a first medical responder form or document the care provided at the scene.[16]

Emergency Medical Response Review Committee (EMRRC)

The institution's EMRRC met monthly to review emergency response cases. The EMRRC performed well and correctly identified the same quality issues that we identified. CCC provided training to its staff as necessary.

Clinician On-Site Inspection

The TTA nurses reported they had adequate staffing to meet the medical needs of the patients; the nurses also assisted in the OHU during evenings and nights. The TTA nursing supervisors regularly performed chart reviews to identify areas for improvement. The CCC nurses reported that they recently completed training on the revised emergency medical response policy and had started to implement the changes.

15. These deficiencies occurred in cases 1, 3, 4, 5, 6, 7, 20.
16. These deficiencies occurred in cases 1 and 3.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Emergency Services**, we offer the following recommendation to the department:

- Nursing leadership should remind first responders and nursing staff to document emergency events thoroughly, accurately, and consistently.

Health Information Management

In this indicator, OIG compliance inspectors evaluated the flow of health information, a crucial link in high-quality medical care delivery. We 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. We also tested whether clinicians adequately reviewed and endorsed those reports, and checked whether staff correctly labeled and organized documents in the medical record.

Overall Rating ***Proficient***

Case Review Rating ***Proficient***

Compliance Score ***Proficient*** **(87%)**

Results Overview

CCC performed well in the health information management indicator. Since our Cycle 5 review, the institution has continued to effectively share information among the medical staff. CCC retrieved hospital and outside emergency department (ED) reports and specialists' progress notes within required time frames. Although our compliance testing identified delays in provider reviews of pathology results and specialty reports, our case reviews did not identify such delays. Overall, we rated this indicator ***proficient***.

Case Review Results

We found only one minor deficiency related to health information management. In this deficiency, the provider did not review the specialty report within required time frames.[17]

Hospital Discharge Reports

CCC performed well with hospital discharge reports. Compliance testing revealed 100 percent of the community hospital discharge documents were scanned into the patient's electronic medical record within three calendar days of discharge (MIT 4.003). Of the four cases we tested, we found that 75 percent of the hospital discharge reports were reviewed by a provider within five calendar days of a patient's discharge (MIT 4.005).

Our case reviewers examined 12 off-site emergency department and hospital visits. We found that CCC continued to perform well in the retrieval of emergency department physician reports and hospital discharge summaries. We found no deficiencies in this area.

Specialty Reports

Compliance testing found CCC retrieved and scanned 87 percent of the high-priority, medium-priority, and routine specialty notes (MIT 4.002). Case reviews found all of the specialty reports were retrieved and scanned into the EHRS within required time frames.

17. This minor deficiency occurred in case 20.

While the institution performed well in the retrieval and scanning of specialty notes, our compliance testing found CCC providers did not review all of these reports on time. Providers reviewed 80 percent of the routine specialty service reports, 73 percent of high-priority reports, and 53 percent of the medium-priority reports within the required time frames (MIT 14.008, MITs 14.002, and 14.005). Case reviews showed better performance; in 39 specialty events, we found only one delay in provider review of specialty reports.[18]

Diagnostic Reports

CCC providers did well in signing most diagnostic reports. However, our compliance testing showed health information management related to pathology reports had room for improvement. Of the four compliance cases sampled, the providers reviewed and endorsed only 25 percent of the pathology reports (MIT 2.011), and none of the providers communicated the results of the pathology study to the patients within the required time frames (MIT 2.012). There were no stat laboratory tests available for review (MIT 2.008).

Urgent and Emergency Records

The institution's on-call providers continued to perform well in documenting their telephone encounters. We did not identify any missing on-call provider documentation.

Scanning Performance

Our compliance inspection revealed medical records staff properly scanned, labeled, and correctly filed patient records correctly in 79 percent of the cases reviewed (MIT 4.004). Case reviewers did not identify any mistakes in the document scanning process, such as mislabeling, misfiling (filed in the wrong chart) or incorrectly dating.

Clinician On-Site Inspection

We observed clinical information transmission during daily morning huddles. We also interviewed various health care staff regarding how information was handled, especially how information was transmitted when patients received care outside the clinic or after hours. Some staff have tracking logs sent to all clinics daily, others send messages to the team, and some discussed issues during their morning huddles. The team also reviewed patients who received care from the community hospital or after-hours clinic; this review included providing additional medical information to the hospital and planning for the patient's return with necessary services, follow-up appointments, and hospital discharge reports. In addition, during the population management meeting, the

18. This deficiency occurred in case 20.

patient care team discussed any system concerns regarding lapses in communication or continuity of care.

The primary care team discussed all patients who received care from the community hospital or after clinic hours during their morning huddles. Information included determining if the primary care team needed to provide additional medical information to the hospital or other higher level of care team planning for the patient's return, such as ensuring necessary services and scheduling follow-up appointments, and ensuring hospital reports were obtained for review.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Health Information Management**, we offer the following recommendations to the department:

- Medical leadership should remind providers to review specialty reports within required time frames.
- Medical leadership should remind providers to review pathology results and communicate these results to the patient within required time frames.

Compliance Testing Results

Table 9. Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	19	1	10	95%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	87%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	4	0	0	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	19	5	0	79%
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) *	3	1	0	75%
				Overall percentage (MIT 4): 87%

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

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

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	N/A	N/A	N/A	N/A
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	1	3	2	25%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	4	2	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	11	4	0	73%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	8	7	0	53%
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) *	12	3	0	80%

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

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

Health Care Environment

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(67%)

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

Results Overview

The institution's performance in this indicator decreased from its performance in Cycle 5. We found some positive elements in CCC's performance in Cycle 6: waiting areas were adequate, clinic environments provided reasonable auditory privacy, medical supply storage areas outside the medical clinics adequately stored medical supplies, the clinical areas were clean, and sterilization equipment was in working order and procedures were followed.

However, other aspects of CCC's health care environment needed improvement: some examination rooms lacked space for examinations; a few clinics contained improperly labeled and expired medical supplies; emergency medical response bag logs were inaccurate or missing staff verification that bag compartments were properly sealed; and most of the CCC staff we observed did not regularly wash their hands before or after examining their patients. These factors resulted in an ***inadequate*** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

We examined outdoor patient waiting areas (Photo 1, right). Health care and custody staff reported that existing waiting areas provided adequate seating capacity. The institution uses the empty dormitory next to the clinic to protect waiting patients during inclement weather (Photo 2, next page.)

Photo 1. Outdoor waiting area (photographed on August 27, 2019).

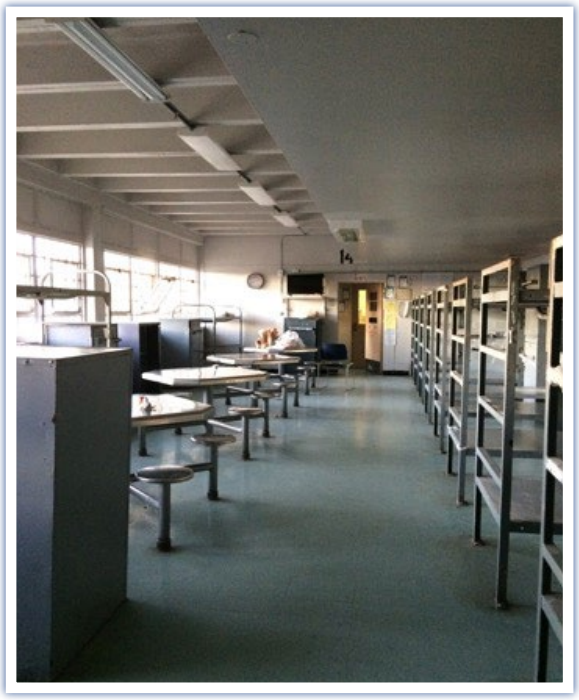


Photo 2. Empty dormitory next to the clinic used during inclement weather (photographed on August 27, 2019).

Indoor Waiting Areas

Inside the medical clinics, the existing indoor waiting areas provided sufficient seating capacity (Photo 3, below, and Photo 4, next page, top). Although we observed several patients standing outside the medical clinic, the patients explained they preferred standing outside to sitting inside the waiting room.

Clinic Environment

Nine of the 10 clinic environments were sufficiently conducive to medical care: they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 90%). In one clinic, the configuration of the vital sign check stations did not provide auditory privacy.

Of the 10 clinics we observed, only four contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 40%).

Photo 3. Indoor waiting area with open seating located in the gymnasium (view 1) (photographed on August 27, 2019).

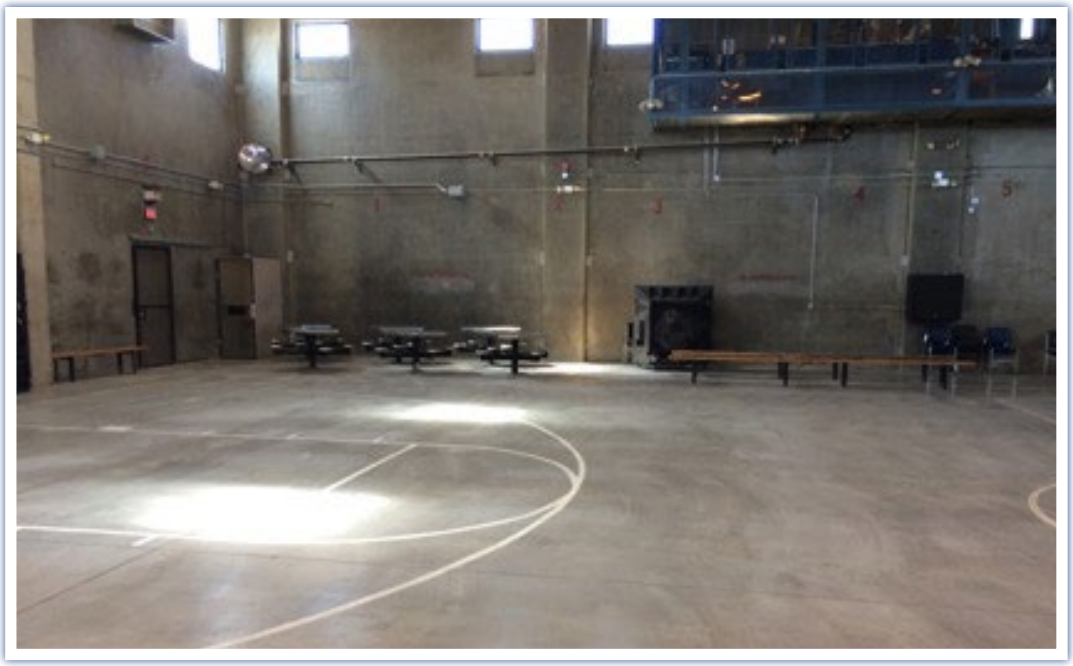


Photo 4. Indoor waiting area with open seating located in the gymnasium (view 2) (photographed on August 27, 2019).

The remaining six clinics had one or more of the following deficiencies: torn examination table covers; examination table placement that impeded the clinician's access to the patient, hindering a full assessment; examination rooms that lacked space, measuring under 100 square feet; or confidential medical records that were accessible to unauthorized individuals.

During our interview with the clinical staff in B yard clinic, we observed multiple alarms activated due to multiple fights among patients. The department explained that these fights resulted from the integration of nonspecified and nonprogramming patients into the yard. Multiple fights in different dormitories that day caused approximately 19 alarms, an abnormally high number for this institution. This caused a disruption of clinic operations, specifically in the RN clinical patient encounters. In response to the extraordinary spike in alarms, several nurse supervisors created a triage area in the yard's gymnasium because the institution's two-bed TTA was overwhelmed.

Clinic Supplies

Five of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 50%). The remaining five clinics had one or more of the following deficiencies: cleaning supplies stored in the same area with medical supplies; food stored in the medical supply storage room; unidentified medical supplies; compromised sterile medical supply packaging; and expired medical supplies (Photos 5 and 6, next page).

Photo 5. Expired medical supplies dated June 2019 (photographed on August 27, 2019).

Five of the 10 clinics met requirements for essential core medical equipment and supplies. The remaining five clinics lacked medical supplies, such as tongue depressors, or contained improperly calibrated or nonfunctional equipment. One clinic lacked a medication refrigerator. Among the nonfunctional equipment, we found one Snellen chart that did not have an identified distance line on the floor or wall, an inadequately functioning overhead light, and a thermometer without a current calibration sticker. We also noted that CCC staff had not accurately logged results of the defibrillator performance test within the preceding 30 days.

Photo 6. Expired medical supplies dated November 2017 (photographed on August 28, 2019).

In addition, nursing staff expressed concerns over not having readily available medical supplies, such as urine test strips and culture swabs, to provide patient care (MIT 5.108, 50%). We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items, and we verified whether staff inspected the bags daily and inventoried them monthly. Only two of the seven EMRBs passed our test. We found one or more of the following deficiencies with five EMRBs: staff failed to ensure the EMRBs' compartments were sealed and intact, and the emergency crash cart contained sterile medical supplies with compromised packaging (MIT 5.111, 29%).

Medical Supply Management

The institution scored 100 percent for this test. The medical supply storage areas outside the clinics (e.g., warehouse, Conex containers, etc.) store clinic medical supplies (MIT 5.106).

According to the chief executive officer (CEO), the institution did not have any concern about the medical supplies process. Health care managers and warehouse manager expressed no concerns about the medical supply chain or their communication process with the existing system. The institution provided an office technician (OT) who coordinated with the nursing supervisor and submitted orders on a weekly basis or as needed.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected nine of 10 clinics. In one clinic, staff allowed the clinic's examination room cabinet to accumulate grime (MIT 5.101, 90%).

Staff in nine of 10 clinics properly sterilized or disinfected medical equipment. In one clinic, when describing their daily protocol, staff did not discuss disinfecting the examination table prior to the start of their shift. In addition, staff did not remove and replace examination table paper after a patient encounter (MIT 5.102, 90%).

We found operating sinks and hand hygiene supplies in the examination rooms in six of 10 clinics. The patient's restrooms in four clinics lacked antiseptic soap and disposable towels (MIT 5.103, 60%).

Photo 7. Blood on the gurney mattress (photographed on August 26, 2019).

We observed patient encounters in six clinics. Clinicians followed good hand hygiene practices in three clinics. In three clinics, clinical staff failed to wash their hands before or after examining their patients, after an invasive procedure, or before donning gloves (MIT 5.104, 50%). Health care staff in nine of 10 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. In one clinic, we found dried blood on and under the gurney's mattress (Photo 7, left) (MIT 5.105, 90%).

Physical Infrastructure

At the time of the compliance inspection, CCC was renovating and adding clinic spaces to five medical clinics. These projects began in 2016, and health care managers estimated completion of projects by summer of 2021. According to the institution's CEO, one clinic's existing doors must be replaced in order to comply with the fire safety building code. The renovation and expansion of this clinic is expected to be completed in July 2020. Despite the delay, the CEO did not believe this will negatively impact the patient care provided (MIT 5.999).

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Health Care Environment**, we offer the following recommendations to the department:

- Medical leadership should ensure staff follow equipment management protocols, such as not storing cleaning supplies in the same area with medical supplies, not storing food in the medical supply storage room, identifying all medical supplies, ensuring medical supply packaging remains sterile, and removing all expired medical supplies.
- Medical leadership should ensure adequate medical supply storage.
- Medical leadership should ensure appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations.
- Health care staff should consistently follow universal hand hygiene precautions during patient encounters.

Table 11. Health Care Environment

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	9	1	0	90%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	9	1	0	90%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	6	4	0	60%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	3	4	50%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	1	0	90%
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)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	5	5	0	50%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	5	5	0	50%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	1	0	90%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	4	6	0	40%
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)	2	5	3	29%
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):	67%

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

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Adequate
(75%)

Transfers

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

Results Overview

The institution's nurses completed initial health screenings within required time frames and ensured medication continuity for newly-arrived patients. The nurses performed face-to-face evaluations and sent prescribed medications when patients left the institution. Most patients returning from the hospital or emergency room received sufficient assessment from the TTA nurses. However, CCC presented various deficiencies in the transfer process that could cause lapses or delays in medical care, such as deficiencies in communicating pertinent health information and referrals. We found deficiencies in the transfer process for camp patients returning from an emergency room visit and poor compliance in completing the health screening and ensuring continuity of hospital-recommended medications for patients transferring in from an outside hospital. Taking compliance testing and case reviews together, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 22 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 17 deficiencies, six of which were significant.[19]

Transfers In

We reviewed ten patients who transferred to CCC from another institution. The R&R nurses completed initial health screenings upon

19. Significant deficiencies occurred in cases 1, 22, 29, and 31. Minor deficiencies occurred in cases 2, 22, 23, 25, 26, 27, 30, and 47.

arrival of the patient in the institution. However, compliance testing found R&R nurses scored poorly in completing initial health screening (MIT 6.001, 0%). All screenings missed one or more pertinent item of information, such as symptoms in tuberculosis (TB) screening and vital signs, within the required time frame.

Medication continuity for transferring patients was excellent, as confirmed in case reviews and compliance testing (MIT 6.003, 100%). Case reviewers did not find deficiencies in medication continuity in yard-to-yard transfers, and compliance testing result was 92 percent (MIT 7.005). There were no en-route cases (patients with a layover at the institution) during the review period.

R&R nurses generally referred newly arrived patients to providers within required time frames, and appointments occurred as requested. However, we identified one significant deficiency and two minor deficiencies.[20] We describe the deficiencies below:

- In case 1, the patient was recently diagnosed with severe sleep apnea. When the patient transferred to CCC, the nurse did not refer him to the provider.
- In cases 2 and 27, the R&R nurse did not refer these newly arrived patients with chronic conditions to the provider within required time frames. Although the patients later received care, the nurse did not follow policy.

Compliance testing found specialty appointments occurred within the required time frame in seven of nine patients who arrived in the institution with pending specialty appointments (MIT 14.010, 78%). Case review identified opportunities for improvement in the following cases:

- In case 1, the patient was diagnosed with sleep apnea and had a recommendation for follow-up for treatment efficacy. The R&R nurse documented the plan to refer the specialty order to the provider but did not request an appointment or inform the provider. As a result, the patient did not see a specialist.
- In case 26, the patient had pending consultations for hepatitis C treatment and shoulder surgery. The R&R nurse did not communicate these pending specialty orders to the specialty department, as required by CCHCS policy.
- In case 29, the patient arrived at the institution with pending specialty orders for dermatology, hand surgery, and neurology. CCC did not reconcile the neurology order; as a result, the appointment did not occur.

Transfers Out

We reviewed seven cases for patients who transferred to other institutions, and we identified four deficiencies, two significant and two

20. A significant deficiency occurred in case 1. Minor deficiencies occurred in cases 2 and 27.

minor.[21] Nurses performed face-to-face evaluations, sent the patients' medications and medical equipment with transfer documents, and administered prescribed medications when patients transferred. We confirmed all transfer documents and required active medications were present in the transfer packages when patients transferred out of the institution (MIT 6.101, 100%).

However, staff did not communicate pending specialty orders to the receiving institution, which caused disruption of medical care in some patients. Four cases had pending specialty appointment orders when the patients transferred. In three of the four cases, staff did not relay these orders to the receiving institution, either through the intra-system transfer form or through a message in the EHRS to the receiving institution's R&R and specialty department:

- In case 29, the patient's physician had ordered dermatology, hand surgery, and neurology referrals and staff did not inform the receiving institution. The specialty appointments were dropped and did not occur when the patient transferred.
- In case 30, the patient had a gastroenterology follow-up, and staff did not communicate the order to the receiving institution. Although the receiving institution identified the specialty order and scheduled the appointment, staff did not follow policy.
- In case 31, the patient had a neurology consultation ordered, and staff did not inform the receiving institution. When the patient transferred to another institution, the order was dropped and the appointment did not occur.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room visit are at high risk for lapses in care quality. These patients have typically experienced severe illness or injury; they require more care and place strain on the institution's resources. Also, 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. We identified three deficiencies, one of which was significant.[22]

We reviewed 12 cases in which patients returned from the emergency department or were discharged from the hospital. CCHCS policy requires that patients transferring from the community hospital go through the TTA. A nurse's face-to-face evaluation of the patient can mitigate risk, ensure patient safety, and maintain continuity of care. The TTA nurse evaluates patients upon return, informs the provider, obtains orders, and schedules provider follow-up appointments.

21. Significant deficiencies occurred in cases 29 and 31. Minor deficiencies occurred in cases 30 and 47.

22. A significant deficiency occurred in case 1. Minor deficiencies occurred in cases 2 and 27.

However, at the time of our review, CCC's local operating procedure on emergency medical care for camp patients allowed the nurse to determine the patient's disposition either to return to the institution's main facility or to the camp without the nurse evaluating the patient face-to-face. Instead, the procedure required camp custody staff to communicate the hospital discharge's instructions to the nurse. In examining the cases of camp patients who were treated in the community emergency room (ER), we noted a pattern in camp patients transfers that could result in delays in care, unsafe placements, or inappropriate levels of care. When communication between staff breaks down, it could place the patient at risk of harm.

The following minor deficiencies illustrate the lapses in this process:

- In case 22, a camp patient was evaluated in the ER for a wound abscess. The ER physician diagnosed cellulitis (skin infection), started the patient on antibiotic medications, and recommended provider follow-up as well as transfer to a facility where medical care and medications could be administered. Instead, the patient was transported back to the camp. The TTA nurse did not document a chart review, the recommendation from the ER, or the communication of the order to the on-call physician at the main facility Without proper care and monitoring, the patient was at risk for worsening infection.
- In case 23, a camp patient was brought to the ER for an eye injury. Without reviewing the hospital's discharge instructions, the TTA nurse instructed the custody staff to send the patient on the next bus run. A nurse evaluated the patient four days later.
- In case 25, a camp patient was treated in the ER for shortness of breath. Although the patient was brought to the institution's main facility, he was not evaluated by the TTA nurse. During our on-site inspection, CCC acknowledged the patient arrived in the R&R but was brought directly to the housing unit.

Compliance testing showed very poor compliance in continuity of hospital-recommended medications (MIT 7.003, 0%). However, when we reviewed the result, we found that only one patient missed a dose of prescribed medication, while the other patients either were not prescribed medications or were prescribed only PRN (as needed) medications. We did not find any care lapses in the cases reviewed. Provider follow-up after hospital or emergency room occurred in a timely manner in all samples we compliance tested (MIT 1.007, 100%). In case reviews, we found that while one nurse did not schedule a provider follow-up, another nurse corrected the error.[23]

Hospital discharge summary or emergency room reports were retrieved within required time frames (MIT 4.003, 100%) and reviewed in three out of four cases by a provider (MIT 4.005, 75%).

23. This deficiency occurred in case 23.

Our clinicians found few documentation errors related to hospitalization events; these errors did not significantly affect the patients' care.[24]

Clinician On-Site Inspection

The institution has designated an R&R nurse to process patients transferring in and out of the institution. Patients returning from the community hospital or emergency room were evaluated in the TTA. The nursing supervisor stated that CCC continued to have a high volume of patients arriving and leaving the institution because of its multiple fire camps; the institution would often assign additional nurses to process these patients. We found the R&R provides sufficient space for nurses to screen and evaluate patients.

Compliance Testing Results

Compliance On-Site Inspection

R&R nurses ensured that all patients transferring out of the institution have their required medications, transfer documents, and assigned durable medical equipment (DME). In addition, R&R nurses performed face-to-face evaluations and verified whether patients had their DME in their possession.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Transfers**, we offer the following recommendations to the department:

- Nursing leadership should remind R&R nurses to properly complete initial intake assessment.
- Medical leadership should review policies for camp patients returning from the hospital emergency department to ensure proper continuity of care.
- Nursing leadership shoulder remind nurses to provide pertinent information, such as pending specialty orders, during transfers to avoid lapses in care.

24. These deficiencies occurred in cases 22 and 23.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	0	25	0	0
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	25	0	0	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	5	0	20	100%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	6	0	0	100%
				Overall percentage (MIT 6): 75%

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

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

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	22	3	0	88%
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) *	4	0	0	100%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	4	0	0	100%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	3	1	0	75%
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) *	0	1	3	0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	23	2	0	92%
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) *	N/A	N/A	N/A	N/A
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	2	0	78%

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

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

Medication Management

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. We 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, we tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Overall Rating ***Inadequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(67%)**

Results Overview

In this indicator, the case review and compliance reviews scored differently. Cycle 6 compliance testing showed CCC improved medication management for transfers and patients receiving TB medications. CCC also performed well in new medication prescriptions. However, chronic and hospital discharge medication continuity performance declined significantly, along with monitoring patients on TB medications. We noted some medication administration delays in specialized medical housing. Although case review rated this indicator adequate, we also identified lapses in medication continuity. We considered all the factors that led to both ratings, and we rated this indicator ***inadequate***.

Case Review Results

We reviewed 30 cases related to medications and found 10 medication deficiencies, which were mostly minor lapses in medication continuity.[25]

New Medication Prescriptions

Since our Cycle 5 review, CCC has continued to administer new prescription medications to their patients within required time frames. We identified a few cases in which patients received their new medications late, but the delays were not clinically significant.[26] Compliance testing revealed that patients received their new medications within required time frames 92 percent of the time (MIT 7.002).

Chronic Medication Continuity

Staff performed acceptably in chronic medication continuity in the cases we reviewed. We identified gaps in medication continuity only in three cases.[27] However, compliance testing showed poor compliance in this area (MIT 7.001, 14%). Of the 14 samples tested, we found 12 patients did not receive their chronic medications within required time frames.

25. Minor deficiencies occurred in cases 2, 20, 22, 23, 24, 25, and 45.
26. These minor deficiencies occurred in cases 20, 25, and 45.
27. These deficiencies occurred in cases 2, 23, and 24.

Hospital Discharge Medications

Our case reviewers noted that patients received their prescribed medications when they returned from an off-site hospital or emergency room. However, our compliance testing, which sampled four patients, revealed a poor score in this area (MI7.003, 0%). Out of the four patients sampled, three patients had medication orders. Two of the three patients only had PRN orders, which we do not test. One patient had a scheduled medication order after hospital discharge that was not delivered within required time frames. However, this error was not clinically significant, as the medication was delayed only a few hours.

Specialized Medical Housing Medications

OHU patients usually received their prescribed medications without delay. Our clinicians found only one instance in which the patient did not receive his medication on time.[28] Although compliance testing showed some delays in this area (MIT 13.004, 70%), only one delay was clinically significant delay in medication continuity.

Transfer Medications

CCC ensured medication continuity for patients transferring into the institution. We did not identify any lapses in the cases we reviewed. Compliance testing also supported this finding (MIT 6.003, 100%).

Compliance testing also found CCC performed well in medication continuity for patients transferring from one housing unit to another within the institution (MIT 7.005, 92%). In our case reviews, we did not find any lapse in medication for patients transferring to other institutions. Compliance testing also showed all patients who transferred out had transfer packages with the required medications and documents (MIT 6.101, 100%).

Medication Administration

CCC nurses administered medications within required time frames. On a few occasions, the nurses did not administer medication because it was not available. Compliance testing examined how CCC nurses administered and monitored patients taking TB medications and found nurses correctly administered TB medications as prescribed (MIT 9.001, 100%). However, nurses did not monitor these patients weekly for side effects of the TB medications (MIT 9.002, 0%), as required by policy.

Clinician On-Site Inspection

We interviewed the pharmacist and nurses during the on-site inspection. The pharmacist reported no medication delivery backlogs. The medication nurses attended daily huddles and informed the care team

28. This deficiency occurred in case 20.

of any medication issues, including patient compliance and diabetic patients' blood sugar trends. The nurses we interviewed articulated the keep-on-person medication delivery process both in the main facility and in the camps.

Compliance Testing Results

Medication Practices and Storage Controls

Staff adequately stored and secured narcotic medications in five of six clinic and medication line locations we reviewed. In one location, the Supervising Nurse II (SRN II) could not describe the narcotic medication discrepancy reporting process (MIT 7.101, 83%).

CCC staff appropriately stored and secured nonnarcotic medications in all eight clinic and medication line locations (MIT 7.102, 100%).

Staff kept medications protected from physical, chemical, and temperature contamination in all eight clinic and medication line locations (MIT 7.103, 100%).

Staff successfully stored valid, unexpired medications in six of the eight medication line locations we examined. In one location, we found a refrigerated multi-dose medication stored beyond the labeled date. In another location, medication nurses failed to label the multi-use medication, as required by CCHCS policy (MIT 7.104, 75%).

Staff exercised proper hand hygiene and contamination control protocols in one of six locations. In five locations, some nurses neglected to wash or sanitize their hands before donning gloves or before each subsequent re-gloving (MIT 7.105, 17%).

Staff in five of six medication preparation and administration areas demonstrated appropriate administrative controls and protocols. In one location, the nurse did not maintain unissued medication in its original labeled packaging (MIT 7.106, 83%).

Staff in two of six medication preparation and administration areas demonstrated appropriate administrative controls and protocols during medication administration. In four locations, we observed one or more instances of the following deficiencies: medication nurses did not reliably observe patients while they swallowed direct observation therapy (DOT) medications, and medication nurses did not appropriately administer medication as ordered by the provider. We observed that a medication nurse did not crush and float the medication administered to the patient as ordered by the provider.[29] A supervising nurse, when interviewed, did not verbalize reporting a medication error to the chief nurse executive (CNE) and the pharmacist-in-charge (PIC); and nurses did not follow insulin protocols properly. When handling insulin prior

29. A medication order to "crush and float" means the nurse must crush the medication and administer the medication in a liquid to the patient.

to administration, medication nurses must perform the following steps: they must verify the insulin was kept in the refrigerator according to the manufacturers' temperature guidelines, and they must complete quality control of the glucometer prior to administering the insulin (MIT 7.107, 33%).

Pharmacy Protocols

Pharmacy staff followed general security, organization, and cleanliness management protocols in its pharmacy (MIT 7.108, 100%). Staff properly stored non-refrigerated (MIT 7.109, 100%) and refrigerated medications (MIT 7.110, 100%).

The PIC did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC did not correctly complete several medication area inspection checklists (CDCR Form 7477). These errors resulted in a score of zero percent in this test (MIT 7.111).

We examined 25 medication error reports. The PIC correctly processed 20 of these 25 reports. In five reports, the PIC did not provide documentation that a pharmacy follow-up review was completed (MIT 7.112, 80%).

Nonscored Tests

In addition to testing the institution's self-reported medication errors, we 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 CCC, we did not find any applicable medication errors (MIT 7.998).

We interviewed a patient in an isolation unit to determine whether he had immediate access to his prescribed asthma rescue inhalers. The patient reported he did not have the prescribed rescue inhaler and indicated he does not need nor want the inhaler. We promptly notified the institution's CEO of the concern, and health care management documented a new patient refusal (MIT 7.999).

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Medication Management**, we offer the following recommendations to the department:

- Medical and pharmacy leadership should ensure that chronic care patients, hospital discharged patients, and specialized medical housing patients receive their medications within required time frames.
- Nursing leadership should remind nursing staff to follow hand hygiene contamination control protocols during medication preparation and medication administration.

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	2	12	11	14%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	23	2	0	92%
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) *	0	1	3	0%
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) *	23	2	0	92%
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) *	N/A	N/A	N/A	N/A
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)	5	1	6	83%
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)	8	0	4	100%
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)	8	0	4	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	6	2	4	75%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	1	5	6	17%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	5	1	6	83%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	2	4	6	33%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	20	5	0	80%
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 isolation 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): 67%

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

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

Table 15. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	5	0	20	100%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	6	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	25	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	0	25	0	0
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	7	3	0	70%

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

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

Preventive Services

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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(68%)

Results Overview

CCC staff had mixed performance in preventive services. Staff performed well in some areas, such as administering the medication as prescribed, offering all patients an influenza vaccine for the most recent influenza season, offering colorectal cancer screening for all patients ages 50 through 75, and offering required immunizations to chronic care patients. However, they faltered in monitoring patients who were taking prescribed TB medication or in screening patients annually for TB. These findings are set forth in the table below. We rated this indicator ***inadequate***.

Compliance Testing Results

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Preventive Services**, we offer the following recommendation to the department:

- Nursing leadership should remind nurses to fully document TB symptoms for monitoring.

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	25	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	0	25	0	0
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	3	22	0	12%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	24	1	0	96%
All patients from the age of 50 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	25	0	0	100%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	10	0	15	100%
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): 68%

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

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

Nursing Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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

When summarizing overall nursing performance, we understand that nurses perform numerous aspects of medical care. Accordingly, we discuss specific nursing quality issues in our evaluations of other indicators, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing**.

Results Overview

We found in our Cycle 6 review that nurses assessed patients adequately and intervened properly. The nurses provided good care coordination for newly-arrived patients and performed competent wound care management. We also found nursing care sufficient in the OHU, in off-site specialty returns, and in medication administration. We identified several nursing deficiencies related to delayed or inappropriate interventions in the emergency, transfers, and sick call processes; however, these nursing deficiencies were limited and could be improved with training and regular monitoring. We found nurses could improve their performance in nursing documentation and nursing care management. We rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 151 nursing encounters in 42 cases. Of the nursing encounters we reviewed, 75 were in the outpatient setting. We identified 43 opportunities for improvement in nursing performance, six of which were significant.[30] We also discussed nursing care in the **Emergency Services** and **Transfers** indicators, in which most deficiencies occurred.

30. Significant deficiencies occurred in cases 1, 9, 25, 29, and 31. The minor deficiencies occurred in cases 1, 2, 3, 4, 5, 6, 7, 18, 20, 23, 24, 26, 27, 30, 33, 36, 38, 39, 40, 42, 44, 46, and 47.

Nursing Assessment

The institution's nurses performed timely and appropriate assessments. Occasionally, nurses did not properly review patients' medical records and did not perform thorough assessments;[31] in one case, a nurse did not evaluate the patient at all.[32] While below the standard of nursing care, these errors occurred intermittently and did not significantly affect patient care. CCC nursing leadership and instructors could use these examples for quality improvement and training:

- In case 2, the patient's blood sugar was very high, yet the nurse did not question the patient or observe the patient for signs and symptoms of hyperglycemia. Despite the lack of nursing assessment, the patient received medication to lower his blood sugar.
- In case 18, the nurse examined the patient on several occasions for extremity pain. However, the clinic nurse did not thoroughly examine the affected area and assess the patient's gait, extremity strength, and range of motion. This nursing error was mostly technical and did not affect patient care.
- In case 24, the nurse administered a nebulizer treatment for shortness of breath and wheezing, but did not establish a clinical baseline by assessing lung sounds and oxygen saturation level before administering the nebulizer treatment. Then the nurse did not assess the lung sounds and oxygen saturation after treatment to determine the effectiveness of the medication.
- In cases 38, 40, and 44, the nurses omitted some nursing assessment by not obtaining the patient's vital signs, not weighing the patient, or not assessing the patient's pain level during the visit.

Nursing Intervention

We noted that while CCC nurses often intervened properly, there were several opportunities for improvement related to emergency care, communication during transfers, and provider referrals. We discuss emergency and transfer issues in those specific indicators. We found CCC nurses sometimes did not refer the patient to the provider or schedule provider appointments appropriately.[33] Except in one case, the institution's health care systems identified and corrected these errors. We also noted nursing intervention deficiencies in following provider orders. We describe an example below:

- In case 39, the provider ordered ear irrigation and a hearing test. The institution had no tuning fork available to perform the hearing test, and the nurse did not inform the provider the test

31. Deficiencies occurred in cases 1, 2, 9, 18, 24, 25, 33, 38, 39, 40, and 44.
32. This deficiency occurred in case 24.
33. Deficiencies occurred in cases 1, 2, 23, 25, 27, 36, and 42.

was not performed. The nurse also did not perform the ear irrigation.

Nursing Documentation

Proper documentation enables transmission of complete and accurate information among health care staff, preventing lapses in care. Overall, CCC nurses wrote clear and concise information. We noted incomplete, inconsistent, or unclear documentation during emergency events and discussed these in the **Emergency Services** indicator.

Nursing Sick Call

We reviewed 48 RN face-to-face sick call encounters. The majority occurred within required time frames; in most encounters, the clinic nurse assessed the patient and intervened correctly. Opportunities for improvement related to improper triage and incomplete assessments, such as in the following examples:

- In case 25, the patient had been recently involved in a fight, had sustained multiple head and face injuries, and complained of continued headaches, nosebleeds, and neck pain. The nurse should have assessed the patient on the same day. When the nurse saw the patient the next day, the patient also complained of blurred vision and decreased hearing. The nurse also noted bruises on the face, arm, and chest area. The clinic nurse should have consulted with the provider or referred the patient to the provider on the same day to evaluate for possible internal injuries.
- In cases 18, 33, 38, 39, 40, and 44, the clinic nurse did not perform a focused assessment, ask pertinent questions related to the patient's symptoms, or obtain the patient's vital signs or weight.

Care Management/Care Coordination

The institution assigned LVNs as care coordinators who reviewed medical records and assessed new patients in their care team. The care coordinator's evaluation was sufficient for most patients. When a patient was considered high-risk or complex, the primary care RN would evaluate the patient. We identified an opportunity for improvement in care management in this case:

- In case 1, the RN inadequately evaluated the newly-arrived patient. The clinic nurse should have reviewed the patient's medical history comprehensively as part of initial care management and noted the patient's recent tests results, specialty reports, and the previous provider's plan of care related to his medical condition.

Wound Care

We reviewed three wound care cases. The nurses performed and documented wound care well.

Emergency Services

As further described in the **Emergency Services** indicator, CCC nurses provided adequate emergency care.

Transfers/Hospital Returns

We noted deficiencies in communicating specialty orders for patients involved in the transfer process. We also found deficiencies in proper disposition of camp patients returning from emergency room visits. Please refer to the **Transfers** indicator for details.

Specialized Medical Housing

The OHU nurses performed well. We did not find any areas for improvement.

Specialty Services

CCC nurses evaluated patients returning from specialty appointments and regularly informed providers of the specialty findings and recommendations. Please refer to the **Specialty Services** indicator for additional discussion.

Medication Management

CCC nurses administered medications on time. The nurses could improve on follow-up with pharmacy when medications are not available for administration. The **Medication Management** indicator provides further information.

Clinician On-Site Inspection

We attended morning huddles on both days of the inspection. We also attended a population management meeting, in which the primary care team discussed in detail topics concerning their patient panel. The medical executive and primary care team reviewed the team's performance and addressed areas with low performance. The team also discussed high-risk or complex patients with specific chronic conditions, reviewed scheduling issues, provided information on new or updated policies, and presented any team concerns.

CCC reported how they provide care to camp patients. Episodic and chronic care appointments of camp patients are monitored by the primary care RN. Patients return to the main facility for these appointments or are seen at a camp facility during scheduled camp visits.

Patients with specialty appointments return to the main facility before the scheduled appointment date. Camp patients who need emergency medical care are transferred to the nearest community hospital.

We discussed the case review questions with the chief nurse executive and nursing director. They provided detailed written and verbal responses. Both nursing managers were familiar with their institution's care system challenges.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Nursing Performance**, we offer the following recommendation to the department:

- Nursing leadership should remind nurses to thoroughly review patients' medical records and perform complete assessments.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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. The OIG assessed provider care through case review only and performed no compliance testing for this indicator.

Results Overview

As a whole, CCC providers performed acceptably. Providers generally made accurate diagnoses and appropriate treatment plans. With a few exceptions, providers reviewed medical records in adequate depth. Chronic care management was satisfactory, with diabetes management offering an area of improvement. CCC providers appropriately referred patients for specialty services. Therefore, we rated this indicator ***adequate***.

Case Review Results

We reviewed 145 face-to-face provider encounters and found 40 provider deficiencies. Of those 40 deficiencies, eight were significant.[34] In addition, we examined the care quality in 20 comprehensive case reviews.

Assessment and Decision-Making

CCC providers generally made sound assessments and accurate diagnosis. Poor assessments and misdiagnoses, although infrequent, did occur. We identified deficiencies in provider assessments in cases 2, 3, 15, 24, and in the following cases:

- In case 4, the provider's examination was superficial and incomplete, given the patient's worsening abdominal pain.
- In case 17, the provider did not perform a thorough physical examination on a patient who was a new arrival.

Review of Records

CCC providers performed acceptably in chart review, which greatly aided in their diagnostic assessments and their ability to provide

34. Significant deficiencies occurred in cases 10, 12, 24, and 25. Minor deficiencies occurred in cases 2, 3, 4, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, and 25.

comprehensive medical care for their patients. We identified two cases with insufficient provider review:

- In case 24, the provider did not thoroughly review the patient's chart to identify a lapse in care—that the antibiotic needed to treat the patient's pneumonia was never ordered. On the subsequent nurse follow-up six days later, the nurse also did not notice that the patient had never received his antibiotic. Due to this oversight by both the provider and the nurse, the patient's pneumonia worsened, and he was subsequently transferred to an outside hospital for further treatment.
- In case 25, the provider did not review the emergency department's record and did not ensure that the patient received the recommended medications.

Emergency Care

CCC emergency care was excellent. The TTA and on-call providers usually made accurate assessments and triage decisions. Providers generally sent patients requiring higher levels of care to a community hospital or emergency department. We did not identify any problems with providers' emergency care assessments or decisions.

Chronic Care

CCC chronic care performance was generally appropriate. However, diabetes management offered opportunities for improvement. Of the five cases of patients with diabetes, we found provider deficiencies in three cases. One provider was responsible for most of the significant deficiencies. Examples follow:

- In case 10, during the review period, the provider did not use the available fingerstick logs and sliding scale to tailor the patient's diabetes treatment. The provider did not always schedule an appropriate interval follow-up appointment to evaluate the effectiveness of the treatment changes.
- In case 12, the provider sporadically made small adjustments to the diabetes treatment rather than using the blood sugar reading information to adjust the treatment to the patient's need. At one point, the provider discontinued standing mealtime insulin orders and initiated a sliding scale treatment plan that resulted in the patient receiving a lower dose than he should have received for uncontrolled diabetes.

Most patients at CCC were low medical complexity and did not require the management of complex medical conditions. The following minor deficiency was identified in the case below:

- In case 2, the provider did not document an abdominal examination given the patient's history of liver cirrhosis

Specialty Services

CCC providers continued to appropriately refer patients for specialty services. Please refer to the **Specialty Services** indicator for further details.

Documentation Quality

In our Cycle 5 review, we identified many instances of insufficient documentation during the case review. At the time, the most common deficiencies were the failure to address one or more medical problems, acute medical issues, inaccurate documentation, and inaccurate documentation to support a medical decision. While these issues have improved since that review, we still found in this review period some evidence of *cloned* progress notes, in which a provider copied outdated medical information and carried that information forward to a current progress note. We identified cloned progress notes in cases 11 and 18. However, we found these cloned progress notes did not significantly impact medical care.

Provider Continuity

We found provider continuity to be sufficient in most of the outpatient cases that we reviewed.

Clinician On-Site Inspection

We observed the daily morning huddles that occurred at CCC and performed on-site interviews. The providers expressed excellent job satisfaction and good morale. At the time of our on-site inspection, the chief physician and surgeon (CP&S) had been only recently promoted to the chief medical executive (CME) position. The providers reported that the new CME continued to be an excellent and approachable leader who provided the necessary support they needed to give quality care to their patients. The new CME was on-site for one week each month and provided guidance and leadership by telemedicine during the time he was away from the institution. At the time of the on-site interviews, we were informed that there were no problems with provider retention, although provider recruitment was still an issue.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Provider Performance**, we offer the following recommendation to the department:

- Medical leadership should remind providers to review and use published CCHCS care guidelines for diabetes.

Specialized Medical Housing

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Proficient*** **(87%)**

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 considered 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, CCC's only specialized medical housing was an outpatient housing unit (OHU).

Results Overview

CCC providers and nurses delivered sufficient care in the Outpatient Housing Unit (OHU). The institution used its OHU beds for brief holds prior to scheduled procedures or diagnostic tests and for observation after hospital discharge. Communication of patient information at the time of discharge between OHU nurses and clinic nurses markedly improved. Staff could improve performance by completing provider history and physical (H&P) exams within required time frames and by administering medication within required time frames. In considering both the case review rating and compliance score, we rated this indicator ***adequate***.

Case Review Results

We reviewed seven OHU cases, which included 18 provider events and 14 nursing events. Because of the care volume that occurs in specialized medical housing units, each provider and nursing event could represent up to one month of provider care and nursing care. We identified four deficiencies, none of which were significant.[35]

Provider Performance

The provider performance in the OHU was generally satisfactory. Providers documented thorough history and physicals for patients newly admitted to the OHU. Our compliance testing found primary care providers completed history and physical examinations (H&Ps) 67 percent of the time (MIT 13.002) and completed progress notes 100 percent of the time (MIT 13.003). Of the 18 OHU provider encounters reviewed, we identified three minor deficiencies, all of which were in one case.[36] Providers performed rounds at clinically appropriate intervals and appropriately reviewed recent laboratory results.

35. The minor deficiencies occurred in cases 4 and 20.
36. We identified these deficiencies in case 4.

Nursing Performance

The nurses completed initial nurse assessment upon patients' admissions to the OHU. These assessments could be either comprehensive, for patients admitted more than one day to the OHU, or focused, for preprocedure placement or overnight observation. Our compliance measure indicated nurses completed an initial assessment of the patient on the day of his admission for all samples tested (MIT 13.001, 100%).

The OHU nurses conducted regular rounds, provided routine care to their patients, and reported any change in condition or new symptoms to the provider. When patients were discharged from the OHU, the nurses contacted the primary care team to transfer care for continuity. Nursing documentation was also clear and usually complete.

Medication Administration

Compliance testing showed deficiencies in nurses' administering medications to patients within the ordered time frame (MIT 13.004, 70%). However, case review identified only one instance in which the patient's medication was delayed.[37]

Clinician On-Site Inspection

At the time of our on-site inspection, CCC had 13 active medical OHU beds, with five patients admitted for preparation prior to scheduled procedures, observation after a procedure, and wound care. Our compliance team tested the call light systems and found all call lights functional (MIT 13.101, 100%). Staffing was adequate and the OHU was also in close proximity to the TTA. The nurses assigned in these areas assisted each other when necessary.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Specialized Medical Housing**, we offer the following recommendation to the department:

- Providers should perform an admission history and physicals examination within the required time frame.

37. There was a delay in administration of the patient's tamsulosin in case 20.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	10	0	0	100%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	2	1	7	67%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *, †	7	0	3	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? (13.004) *	7	3	0	70%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	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	1	N/A
				Overall percentage (MIT 13): 87%

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

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

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

Overall Rating
Adequate

Case Review Rating
Proficient

Compliance Score
Adequate **(84%)**

Specialty Services

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

Results Overview

Since our Cycle 5 review, CCC has continued to provide reliable care in specialty services within required time frames for routine and urgent services. Providers also appropriately used specialty services; we did not identify any inappropriate provider referrals. Both on-site and off-site specialty reports were accessible to the providers. CCC leadership has continued to efficiently use telemedicine services to provide good specialty access. However, there was room for improvement in completing specialty services within required time frames upon the patient's transfer into the institution and ensuring providers reviewed the specialty reports within required time frames. We rated this indicator ***adequate***.

Case Review Results

We reviewed 55 events related to specialty services, of which 41 were specialty consultations and procedures. We identified only two deficiencies in this category, one of which was significant.[38]

Access to Specialty Services

In routine and medium-priority specialty referrals, CCC performed well. Our case reviews found no deficiencies in specialty referrals, and our compliance testing showed similar results, with 100 percent and 93 percent compliance scores (MIT 14.007 and MIT 14.004). Our compliance testing also showed that CCC performed well in high-priority specialty referrals, with a score of 87 percent (MIT 14.001).

However, for patients transferring in from another institution, CCC demonstrated room for improvement. Our compliance testing found CCC completed specialty services within the required time frames for 78 percent of the patients we tested (MIT 14.010). Our case review identified one significant deficiency:

- In case 29, staff did not reconcile the pending specialty orders for the neurologist upon the patient's transfer in process. As a result, the patient did not see the specialist.

38. The significant deficiency occurred in case 29; the minor deficiency occurred in case 20.

Provider Performance

CCC providers appropriately used specialty services. Providers performed proficiently in submitting appropriate referrals for specialty services. Furthermore, we found that providers submitted all of the referrals within the required priority time frame.

Our compliance testing found similar results: patients who returned from specialty services saw their providers promptly (MIT 1.008, 90%).

Nursing Performance

We reviewed nursing encounters during telemedicine specialty appointments and after patients returned from off-site specialty appointments. Overall, the nurses performed well in assessing patients, reviewing the specialty reports, and informing providers of the findings and recommendations.

We identified opportunities for improvement in the specialty services' process for patients transferring into and out of the institution. We found instances wherein nurses did not reconcile specialty orders when patients transferred into the institution or did not convey specialty appointments to the receiving institutions. We discussed these cases in the **Transfers** indicator. Although these errors occurred during transfers, specialty services could also examine these lapses for quality improvement.

Health Information Management

CCC's performance processing specialty reports needs improvement. Providers usually reviewed routine reports within the required time frame, achieving a compliance score of 80 percent (MIT 14.008). However, compliance testing revealed providers reviewed only 53 percent (MIT 14.005) of the medium-priority specialty reports and 73 percent (MIT 14.002) of the high-priority specialty reports within the required time frames. Case reviewers identified one deficiency in which the provider did not review the specialty report within required time frames.

The institution performed well in scanning specialty documents into the electronic health record. Our compliance testing showed CCC scanned 87 percent of the specialty documents in the cases tested within required time frames (MIT 4.002).

Clinician On-Site Inspection

The telemedicine clinic was clean and adequate. We found no appointment backlog for telemedicine specialty services.

All of the providers reported having good access to on-site and off-site specialty services since our Cycle 5 review. The off-site specialty nurse

reported obtaining all of the specialty and hospital reports and then notifying the providers through the EHRS via the message center.

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 in **Specialty Services**, we offer the following recommendation to the department:

- Medical leadership should review specialty report retrieval requirements with staff and ensure providers review specialty reports within required time frames.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	13	2	0	87%
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) *	11	4	0	73%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	3	1	11	75%
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) *	14	1	0	93%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	8	7	0	53%
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) *	15	0	0	100%
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) *	12	3	0	80%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	8	0	7	100%
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	2	0	78%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	16	4	0	80%
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%
				Overall percentage (MIT 14): 84%

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

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

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	35	4	6	90%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	87%

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

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

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

Administrative Operations

Overall Rating ***Proficient***

Case Review Rating **(N/A)**

Compliance Score ***Proficient*** **(86%)**

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

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

Results Overview

CCC staff scored 100 percent in all applicable testing areas, with the exception of the Emergency Medical Response Review Committee's (EMRRC) reviewing cases within required time frames and the incident packages including the required documents, and excepting the institutions' performance in conducting medical emergency response drills during each watch of the quarter and in the health care and custody staff's participation in those drills. These findings are set forth in the table below. We rated this indicator ***proficient***.

Compliance Testing Results

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. One unexpected (Level 1) death occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of the death. When the DRC completes the death review summary report, it must submit the report to the institution's CEO within seven calendar days after completion. During our inspection, we found the DRC finished the report 30 days late and submitted the report to the institution's CEO 15 days later than the required seven-day time frame (MIT 15.998).

CCHCS provides health care staffing data to the OIG. We present the CCC's health care staffing data in the administrative operations table (MIT 15.999).

Recommendations

As a result of our assessment of CCC's performance during Cycle 6 for **Administrative Operations**, we offer the following recommendation to the department:

- The EMRRC should review emergency medical response incidents punctually at the regular monthly meeting following the date of the incidents.

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	4	8	0	33%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent, meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	100%
Did the responses to medical grievances address all of the inmates' grieved issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	1	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	2	0	0	100%
Did the providers maintain valid state medical licenses? (15.106)	2	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)	5	0	2	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): 86%			

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

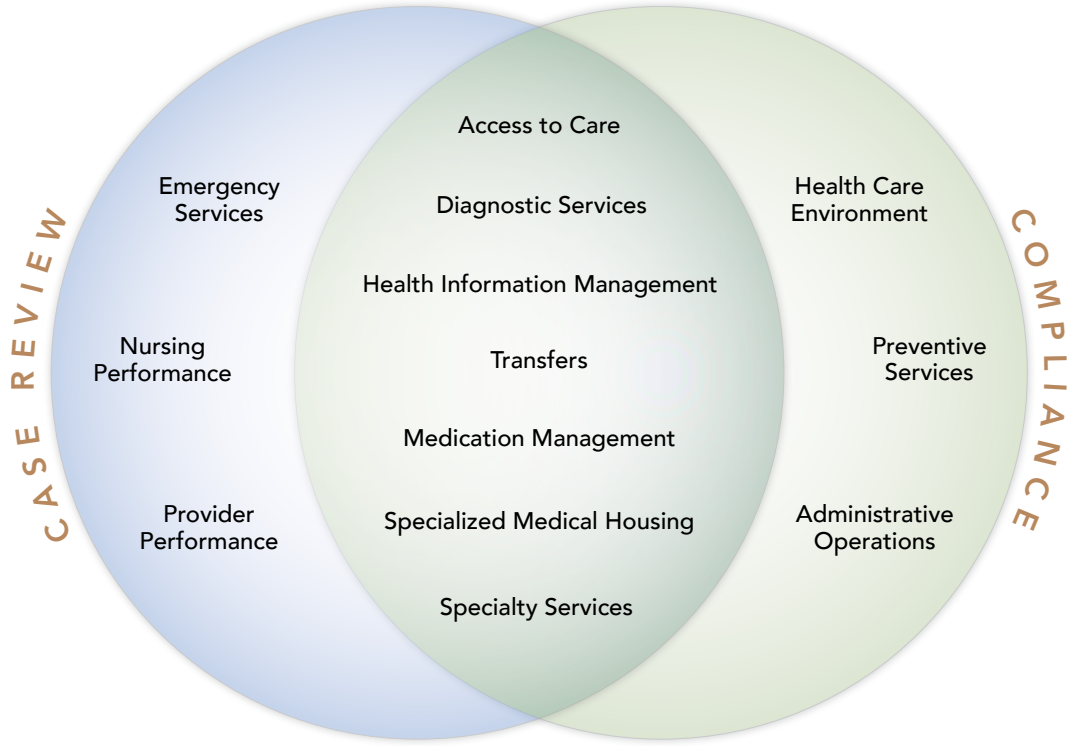
(This page left blank for reproduction purposes.)

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 CCC



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

Case Reviews

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

Table A–1. Case Review Definitions

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

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinician 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 standardized protocol and select samples for clinicians to review. Samples are obtained per the case review methodology shared with stakeholders in prior cycles. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

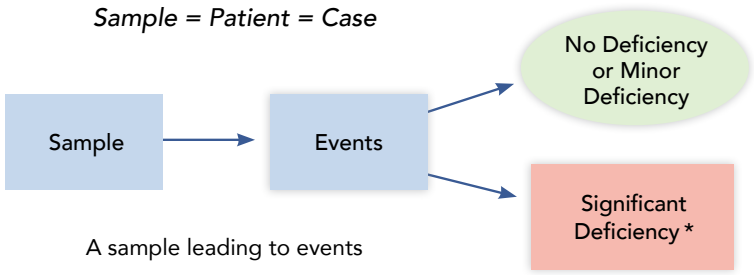
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

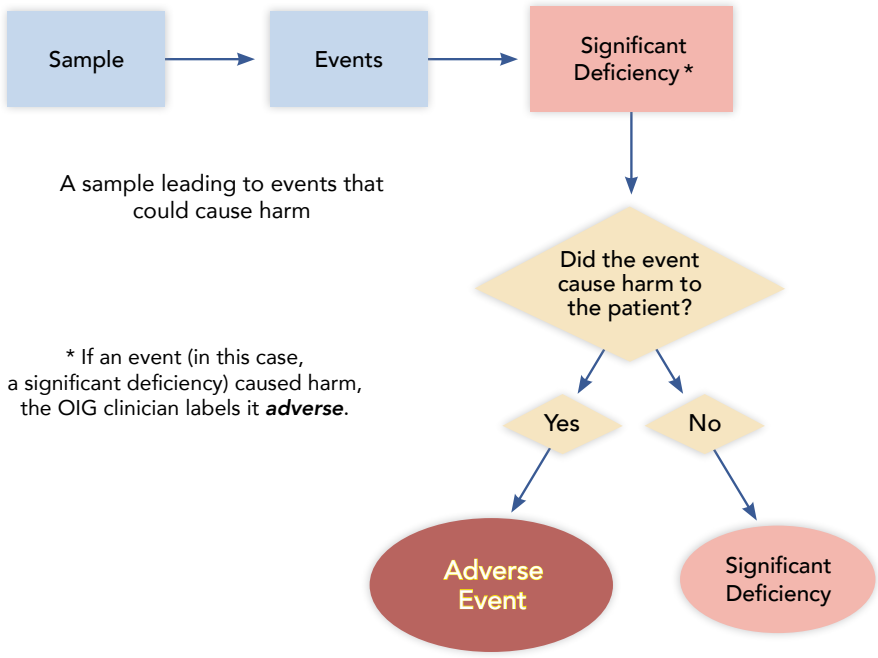
Figure A–2. Case Review Testing

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***.



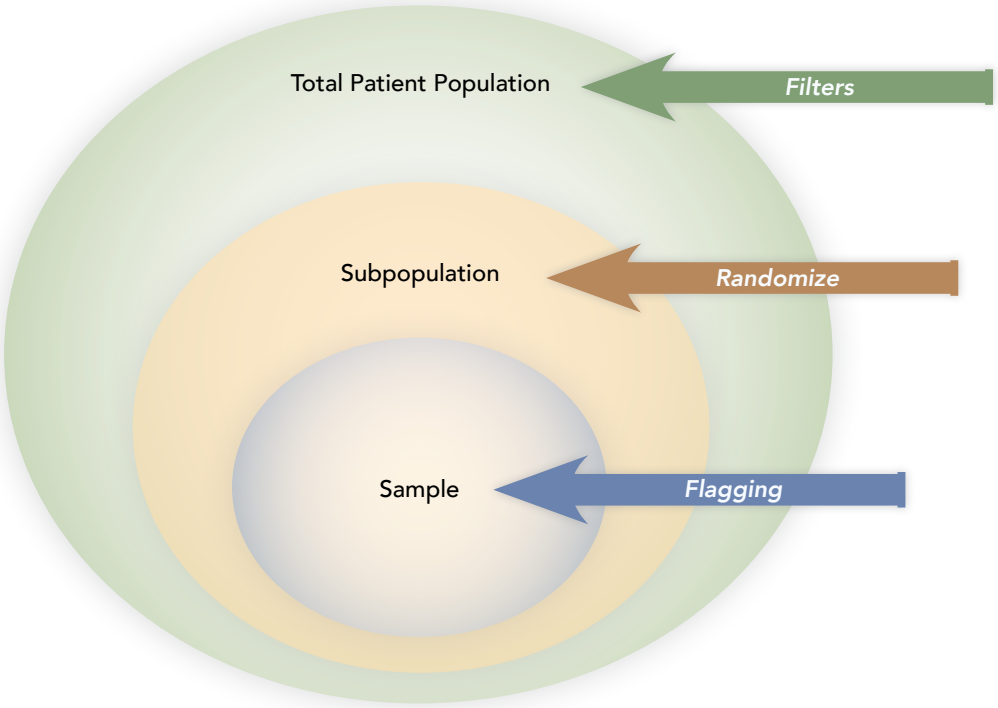
Source: The Office of the Inspector General medical inspection analysis.

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 also 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*** (greater than 85 percent), ***adequate*** (between 75 percent and 85 percent), or ***inadequate*** (less than 75 percent).

Indicator Ratings and the Overall Medical Quality Rating

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

Appendix B. Case Review Data

Table B–1. Case Review Sample Sets

Sample Set	Total
Anticoagulation	0
CTC/OHU	3
Death Review/Sentinel Events	1
Diabetes	4
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	15
Specialty Services	4
	49

Table B–2. Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	0
Anticoagulation	0
Arthritis/Degenerative Joint Disease	3
Asthma	12
COPD	0
Cardiovascular Disease	3
Chronic Kidney Disease	1
Chronic Pain	6
Cirrhosis/End-Stage Liver Disease	3
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	0
Diabetes	8
Gastroesophageal Reflux Disease	3
Hepatitis C	10
Hyperlipidemia	14
Hypertension	9
Mental Health	0
Migraine Headaches	1
Seizure Disorder	3
Sleep Apnea	6
Thyroid Disease	0
	83

Table B–3. Case Review Events by Program

Diagnosis	Total
Diagnostic Services	116
Emergency Care	45
Hospitalization	17
Intrasystem Transfers In	10
Intrasystem Transfers Out	7
Not Specified	1
Outpatient Care	265
Specialized Medical Housing	48
Specialty Services	71
	580

Table B–4. Case Review Sample Summary

MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	12
RN Reviews Focused	29
Total Reviews	61
Total Unique Cases	49
Overlapping Reviews (MD & RN)	12

Appendix C. Compliance Sampling Methodology

California Correctional Center

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	4	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	N/A	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	6	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	20	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	30	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	4	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	4	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	10	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	6	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	4	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	N/A	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	25	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	Isolation Unit KOP Medications	1	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation 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	25	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 (51 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 (number will vary)	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 12.001–008	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 13.001–004	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MIT 13.101	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	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MIT 14.010	Specialty Services Arrivals	9	MedSATS	• 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
		0	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	1	OIG summary log: deaths	• Between 35 business days & 12 months prior • Health Care Services death reviews

California Correctional Health Care Services' Response

July 22, 2020

Roy Wesley, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California Correctional Center (CCC) conducted from March to September 2019. Although it is likely CCC may have potential disputes with the OIG findings, all resources are currently focused on direct patient care and containment of the coronavirus. California Correctional Health Care Services (CCHCS) will acknowledge the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,

DeAnna Gouldy
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Katherine Tebrock, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Jennifer Barretto, Director, Health Care Policy and Administration, CCHCS
Joseph Bick, M.D., Director, Health Care Services, CCHCS
Vince Cullen, Director, Health Care Operations and Corrections Services, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Lara Saich, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbra Barney-Knox, R.N., Deputy Director (A), Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Eureka Daye, Ph.D., Regional Health Care Executive, Region I, CCHCS
Jasdeep Bal, M.D., Regional Deputy Medical Executive, Region I, CCHCS
Deborah Bradford, R.N., Regional Nursing Executive, Region I, CCHCS
Robert Duncan, Chief Executive Officer, CCC
Amanda Oltean, Staff Services Manager II, Health Care Compliance Support Section, CCHCS
Kristine Lopez, Staff Services Manager I, Health Care Compliance Support Section, CCHCS
Misty Polasik, Staff Services Manager I, OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

(This page left blank for reproduction purposes.)

Cycle 6
Medical Inspection Report

for

California
Correctional Center

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
September 2020

OIG