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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

August 2024

# *Cycle 7*

## *Medical Inspection Report*

## *California Medical Facility*

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# Introduction

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

In Cycle 7, the OIG continues to apply the same assessment methodologies used in Cycle 6, including clinical case review and compliance testing. Together, these methods assess the institution's medical care on both individual and system levels by providing an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk, who tend to access services at the highest rate. Through these methods, the OIG evaluates the performance of the institution in providing sustainable, adequate care. We continue to review institutional care using 15 indicators as in prior cycles.[3]

Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the medical inspection tool (MIT). In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff. The OIG determines a total compliance score for each applicable indicator and considers the MIT scores in the overall conclusion of the institution's compliance performance.

In conducting in-depth quality-focused reviews of randomized cases, our case review clinicians examine whether health care staff used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient. At the same time, our clinicians consider whether institutional medical processes led to identifying and correcting individual or system errors, and we examine whether the institution's medical system mitigated the error. The OIG rates each applicable indicator ***proficient***, ***adequate***, or ***inadequate,*** and considers each rating in the overall conclusion of the institution's health care performance.

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

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

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

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

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of California Medical Facility, the institution had not been delegated back to the department by the receiver.[4]

We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from October 2022 to March 2023.[5]

[4] As of July 25, 2024, California Medical Facility was delegated back to the department by the receiver.

[5] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between May 2022 and December 2022, and cardiopulmonary resuscitation reviews between September 2022 and April 2023.

# Summary: Ratings and Scores

We completed the Cycle 7 inspection of California Medical Facility in August 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between October 2022 and March 2023.


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


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

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 63 cases, which contained 1,338 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in August 2023 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our physicians rated 15 ***adequate*** and 10 ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

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 366 patient records and 1,262 data points, and used the data to answer 93 policy questions. In addition, we observed CMF's processes during an on-site inspection in June 2023.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in 13 health care indicators.[6]

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

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

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

| | | *Ratings* | | *Scoring Ranges* | | |
|---|---|---|---|---|---|---|
| | | *Proficient* *Adequate* *Inadequate* | | 100%–85.0% 84.9%–75.0% 74.9%–0 | | |
| | | **Case Review** | | **Compliance** | | |
| **MIT Number** | **Health Care Indicators** | **Cycle 7** | **Change Since Cycle 6*** | **Cycle 7** | **Cycle 6** | **Change Since Cycle 6*** |
| 1 | Access to Care | *Adequate* | = | 78.1% | 82.0% | = |
| 2 | Diagnostic Services | *Inadequate* | ↓ | 55.0% | 52.5% | = |
| 3 | Emergency Services | *Inadequate* | ↓ | N/A | N/A | N/A |
| 4 | Health Information Management | *Inadequate* | = | 70.9% | 66.4% | = |
| 5 | Health Care Environment† | N/A | N/A | 63.1% | 69.7% | = |
| 6 | Transfers | *Adequate* | = | 55.8% | 62.6% | = |
| 7 | Medication Management | *Adequate* | ↑ | 53.4% | 61.6% | = |
| 8 | Prenatal and Postpartum Care | N/A | N/A | N/A | N/A | N/A |
| 9 | Preventive Services | N/A | N/A | 69.2% | 56.2% | = |
| 10 | Nursing Performance | *Inadequate* | = | N/A | N/A | N/A |
| 11 | Provider Performance | *Inadequate* | ↓ | N/A | N/A | N/A |
| 12 | Reception Center | N/A | N/A | N/A | N/A | N/A |
| 13 | Specialized Medical Housing | *Inadequate* | = | 65.0% | 66.0% | = |
| 14 | Specialty Services | *Inadequate* | ↓ | 53.5% | 68.5% | = |
| 15 | Administrative Operations† | N/A | N/A | 66.2% | 79.4% | ↓ |

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

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

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

# Medical Inspection Results

## Deficiencies Identified During Case Review

*Deficiencies* are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[7]

The OIG did not find any adverse events at CMF during the Cycle 7 inspection.

## Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to CMF. Of these 10 indicators, OIG clinicians rated three ***adequate*** and seven ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 15 were ***adequate*** and 10 were ***inadequate***. In the 1,338 events reviewed, there were 451 deficiencies, 101 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 CMF:

- Staff provided excellent overall provider and nurse access for patients.
- The nurses and physicians documented their clinical encounters well.
- The physicians provided excellent care for hospice patients.

Our clinicians found the following weaknesses at CMF:

- The providers did not consistently include all required elements for patient test result notification letters.
- The providers had opportunities for improvement in patient assessment, medical decision making, and review of records.
- The nurses had opportunities for improvement in triaging presenting symptoms and patient assessment.
- The nurses often had delays in timely activating EMS for emergent situations.

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

- The institution struggled to provide adequate access to diagnostic and specialty services.

## Compliance Testing Results

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

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

- Nurses reviewed health care services request forms and conducted face-to-face encounters within required time frames.
- Staff offered influenza vaccination and provided colorectal cancer screenings to patients.
- Providers and nurses completed assessments of patients admitted to the specialized medical housing unit within required time frames.

CMF showed a low rate of policy compliance in the following areas:

- Staff performed poorly in ensuring approved specialty services were provided timely. Furthermore, providers sporadically reviewed specialty service reports within specified time frames.
- Providers needed improvement in reviewing radiology results. Furthermore, providers often sent incomplete patient test result letters. Patient letters were missing the date of diagnostic service, the date of the results, and whether the results were within normal limits.
- Staff frequently did not maintain medication continuity for chronic care patients, patients discharged from the hospital, patients admitted to a specialized medical housing unit, patients who transferred into the institutions, patients who transferred within the institution, and patients who had a temporary layover at CMF.
- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.
- Nursing staff occasionally inspected emergency response bags.

## Institution-Specific Metrics

California Medical Facility (CMF), established in 1955, is located in Vacaville, California. CMF provides health care to patients who reside in a number of settings, including general population, outpatient housing units (OHUs), a licensed correctional treatment center (CTC), outpatient psychiatric facilities, and the first licensed prison hospice in the United States. CMF is designated an intermediate care facility; these types of institutions are located in predominantly urban areas, close to tertiary care centers and specialty care

providers for the most cost-effective care. As of March 4, 2024, the department reports on its public tracker that 85 percent of CMF's incarcerated population is fully vaccinated while 78 percent of CMF's staff is fully vaccinated.[8]

In May 2023, the Health Care Services Master Registry showed that CMF had a total population of 1,967. A breakdown of the medical risk level of the CMF population as determined by the department is set forth in Table 2 below.[9]

**Table 2. CMF Master Registry Data as of May 2023**

| Medical Risk Level | Number of Patients | Percentage* |
|---|---|---|
| High 1 | 632 | 32.1% |
| High 2 | 456 | 23.2% |
| Medium | 656 | 33.4% |
| Low | 223 | 11.3% |
| **Total** | **1,967** | **100.0%** |

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 5-24-23.

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

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, CMF had no vacant executive leadership positions, 3.5 primary care provider vacancies, 20.8 nursing supervisor vacancies, and 74.6 nursing staff vacancies.

**Table 3. CMF Health Care Staffing Resources as of May 2023**

| Positions | Executive Leadership* | Primary Care Providers | Nursing Supervisors | Nursing Staff † | Total |
|---|---|---|---|---|---|
| Authorized Positions | 6.0 | 21.5 | 75.8 | 545.5 | 648.8 |
| Filled by Civil Service | 6.0 | 18.0 | 55.0 | 470.9 | 549.9 |
| Vacant | 0 | 3.5 | 20.8 | 74.6 | 98.9 |
| Percentage Filled by Civil Service | 100% | 83.7% | 72.6% | 86.3% | 84.8% |
| | | | | | |
| Filled by Telemedicine | 0 | 1.0 | 0 | 0 | 1.0 |
| Percentage Filled by Telemedicine | 0 | 4.7% | 0 | 0 | 0.2% |
| Filled by Registry | 0 | 1.0 | 0 | 60.0 | 61.0 |
| Percentage Filled by Registry | 0 | 4.7% | 0 | 11.0% | 9.4% |
| | | | | | |
| Total Filled Positions | 6.0 | 20.0 | 55.0 | 530.9 | 611.9 |
| **Total Percentage Filled** | **100%** | **93.0%** | **72.6%** | **97.3%** | **94.3%** |
| | | | | | |
| Appointments in Last 12 Months | 0 | 5.0 | 14.0 | 64.0 | 83.0 |
| Redirected Staff | 1.0 | 2.0 | 0 | 0 | 3.0 |
| Staff on Extended Leave ‡ | 0 | 2.0 | 1.0 | 6.0 | 9.0 |
| | | | | | |
| **Adjusted Total: Filled Positions** | **5.0** | **16.0** | **54.0** | **524.9** | **599.9** |
| **Adjusted Total: Percentage Filled** | **83.3%** | **74.4%** | **71.2%** | **96.2%** | **92.5%** |

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 7 medical inspection preinspection questionnaire received on February 1, 2023, from California Correctional Health Care Services.

## Population-Based Metrics

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

## HEDIS Results

We considered CMF's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only one HEDIS measure is available for review: poor HbA1c control, which measures the percentage of diabetic patients who have poor blood sugar control. CMF's results compared favorably with those found in State health plans for this measure. We list the applicable HEDIS measures in Table 4.

### Comprehensive Diabetes Care

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

### Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. CMF had an 87 percent influenza immunization rate for adults 18 to 64 years old and a 90 percent influenza immunization rate for adults 65 years of age and older.[10] The pneumococcal vaccination rate was 86 percent.[11]

### Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. CMF had a 50 percent colorectal cancer screening rate.

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

[11] The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV15, and PCV20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than where the patient was currently housed during the inspection period.

**Table 4. CMF Results Compared With State HEDIS Scores**

| HEDIS Measure | CMF Cycle 7 Results* | California Medi-Cal† | California Kaiser NorCal Medi-Cal† | California Kaiser SoCal Medi-Cal† |
|---|---|---|---|---|
| HbA1c Screening | 97% | – | – | – |
| Poor HbA1c Control (> 9.0%) ‡,§ | **6%** | 38% | 28% | 20% |
| HbA1c Control (< 8.0%) ‡ | 85% | – | – | – |
| Blood Pressure Control (< 140/90) ‡ | 82% | – | – | – |
| Eye Examinations | 56% | – | – | – |
| Influenza – Adults (18–64) | 87% | – | – | – |
| Influenza – Adults (65+) | 90% | – | – | – |
| Pneumococcal – Adults (65+) | 86% | – | – | – |
| Colorectal Cancer Screening | 50% | – | – | – |

*Notes and Sources*

* Unless otherwise stated, data were collected in June 2023 by reviewing medical records from a sample of CMFs 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, 2021–June 30, 2022 (published April 2023); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2021-22-MCMC-EQR-TR-VOL1-F1.pdf**.

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

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

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

## Recommendations

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

### Access to Care

- Medical leadership should evaluate the root cause(s) of challenges in the timely provision of chronic care follow-up appointments and should implement remedial measures as appropriate.

### Diagnostic Services

- Medical leadership should analyze the root cause(s) of challenges with untimely reviewing and endorsing of radiology and pathology reports and should implement remedial measures as appropriate.

- Medical leadership should analyze the root cause(s) of challenges with untimely collecting, receiving, and notifying providers of STAT laboratory results and should implement remedial measures as appropriate.

- The department should consider developing strategies, such as an electronic solution, to ensure providers generate letters communicating results to their patients and that the letters include all elements as required by policy.

### Emergency Services

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

- Nursing leadership should ensure nursing supervisors are trained on thoroughly completing the emergency medical response review checklist. In addition, nursing and medical leadership should audit CMF's emergency events to identify any opportunities for improvement with providers and nurses.

### Health Information Management

- Medical leadership should evaluate challenges to ensuring documents, including specialty documents and hospital discharge reports, are properly scanned and labeled in the electronic health record as required by CCHCS policy and should implement remedial measures as appropriate.

- Medical leadership should evaluate challenges to providers timely reviewing hospital discharge reports and should implement remedial measures as appropriate.

### Health Care Environment

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

- Executive leadership should analyze the root cause(s) for staff not ensuring medical supply storage areas, located inside and outside the clinics, store medical supplies properly and should implement remedial measures as appropriate.

- Nursing leadership should analyze the root cause(s) for staff not ensuring clinic examination rooms contain calibrated functional essential core medical equipment and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the emergency medical response bags (EMRBs) are regularly inventoried and sealed or failing to properly complete the monthly logs and should implement remedial measures as appropriate.

### Transfers

- The department should analyze the challenges to ensuring R&R nurses properly and thoroughly complete initial health screening questions and follow up as needed and should implement remedial measures as appropriate.

- Nursing leadership should analyze the challenges for nurses in documenting pending specialty referrals for patients transferring to other institutions and should implement remedial measures as appropriate.

### Medication Management

- The institution should determine the root cause(s) of challenges to ensuring staff timely make available and administer medications to patients as well as document the electronic health record, as described in CCHCS policy and procedures, and should implement remedial measures as appropriate.

### Preventive Services

- Nursing leadership should consider developing and implementing measures to ensure nursing staff documents on the MAR summaries patient refusals and no-shows in accordance with CCHCS' policies and procedures.

- Nursing leadership should analyze the challenges in ensuring nursing staff monitor and address symptoms of patients receiving TB medications according to CCHCS guidelines and should implement remedial measures as appropriate.

- Medical leadership should analyze the challenges related to the untimely provision of preventive vaccines to chronic care patients and should implement remedial measures as appropriate.

### Nursing Performance

- Nursing leadership should determine the challenges to nurses performing appropriate triage of sick calls, completing thorough face-to-face assessments, and co-consulting with providers when needed and should implement remedial measures as appropriate.

### Provider Performance

- The department should analyze the challenges to the recruitment and retention of providers at CMF and should implement remedial measures as appropriate.

- Medical leadership should analyze the challenges to providers documenting physical exams based on the patient's clinical presentation during an appointment and should implement remedial measures as appropriate.

- Medical leadership should determine the root cause(s) for providers not thoroughly addressing chronic conditions such as diabetes and should implement remedial measures as appropriate.

### Specialized Medical Housing

- Nursing leadership should analyze the challenges to SMH nurses not performing complete assessments, recognizing changes in patient status, or intervening timely and appropriately and should implement remedial measures as appropriate.

- Leadership should analyze the root cause(s) for CTC staff not activating the 9-1-1 system immediately for emergent patients requiring a higher level of care and should implement remedial measures as appropriate.

- Medical leadership should analyze the root cause(s) for providers not completing accurate documentation and not making appropriate decisions and should implement remedial measures as appropriate.

### Specialty Services

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

- Medical leadership should determine the root cause(s) of challenges to the timely retrieval, scanning, and endorsement of specialty reports and should implement remedial measures as appropriate.

# Access to Care

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

## *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Adequate*** | ***Adequate* (78.1%)** |

Case review found CMF performed well in this indicator for Cycle 7, as it did in Cycle 6. Staff offered very good access to nurses and follow-up after specialty services and hospitalizations. In addition, staff usually completed clinic and specialized medical housing provider appointments. However, CMF needed improvement in access for providers after patients' TTA encounters. Factoring in all the information, OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed good performance in this indicator. CMF scored well in reviewing patient sick call requests, completing face-to-face nurse encounters, offering follow-up nurse-to-provider referrals, and providing follow-ups for patients transferring into the institution and returning from hospitalization. However, CMF scored low in completing provider follow-up appointments for patients with chronic care conditions and returning from specialty services. Factoring testing results, the OIG rated the compliance testing component of this indicator ***adequate***.

## Case Review and Compliance Testing Results

OIG clinicians reviewed 246 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. We identified 10 deficiencies related to **Access to Care**, seven of which were significant.

### Access to Care Providers

CMF's performance was mixed in providing access to providers. Compliance testing showed CMF needed improvement with chronic care follow-up appointments (MIT 1.001, 56.0%) but offered very good access for nurse-to-primary care provider referrals (MIT 1.005, 86.7%). Case review clinicians found one deficiency in the scheduling of provider appointments, which was considered significant:

- In case 17, the nurse evaluated the patient for hand pain and memory loss. The nurse arranged a 14-day primary care provider follow-up appointment; however, the appointment occurred 23 days later.

Due to movement restrictions related to the COVID-19 pandemic, we considered most cases of provider chart reviews to have been triage of nonurgent, low- or medium-risk chronic care appointments and acceptable alternatives to face-to-face or telephonic visits.

### Access to Specialized Medical Housing Providers

CMF provided excellent access to specialized medical housing providers. Compliance testing showed providers always completed the history and physical examinations within the required time frame (MIT 13.002, 100%). Case review found no deficiencies in provider rounding but identified one significant deficiency regarding a follow-up appointment:

- In case 25, the provider ordered a follow-up procedure appointment for a patient housed in the specialized medical housing unit. However, the appointment never occurred.

### Access to Clinic Nurses

CMF performed very well in access to nurse sick calls and provider-to-nurse referrals. Compliance testing showed the nurses frequently reviewed patient requests for service on the same day the requests were received (MIT 1.003, 87.5%) and frequently completed face-to-face appointments within one business day (MIT 1.004, 85.0%). Our clinicians assessed 51 nursing sick call requests and identified one deficiency related to clinic nurse access, which was not significant.[12]

### Access to Specialty Services

CMF provided mixed access to specialty services. Compliance testing showed staff needed improvement with completion of specialty referrals for high-priority (MIT 14.001, 66.7%), medium-priority (MIT 14.004, 53.3%), and routine-priority (MIT 14.007, 66.7%) appointments. In contrast, follow-up specialty appointments often occurred timely (MIT 14.003, 80.0%). Case review clinicians found most specialty appointments occurred within requested time frames; however, we identified two deficiencies, both of which were considered significant.[13]

We discuss this further in the **Specialty Services** indicator.

### Follow-Up After Specialty Services

Compliance testing revealed a majority of provider appointments after specialty services occurred within the required time frame (MIT 1.008, 66.7%). OIG clinicians identified one deficiency, which was not considered significant.[14]

[12] A nonsignificant deficiency occurred in case 17.

[13] Deficiencies occurred in cases 3 and 25. Both deficiencies were significant.

[14] A nonsignificant deficiency occurred in case 22.

### Follow-Up After Hospitalization

Providers frequently evaluated patients after hospitalizations (MIT 1.007, 78.6%). Case review found no deficiencies related to provider follow-up after hospitalization.

### Follow-Up After Urgent or Emergent Care (TTA)

Providers generally evaluated their patients following a triage and treatment area (TTA) event as requested. OIG clinicians assessed 35 TTA events and identified three delays in provider follow-up appointments. These three significant deficiencies occurred in case 19 and are described below:

- The TTA nurse assessed the patient for a headache. However, the patient was not evaluated by a provider within the required time frames for a follow-up appointment after a TTA encounter.
- The patient presented to the TTA for a rash due to urticaria.[15] However, the provider follow-up appointment did not occur within five days as required.
- The patient presented to the TTA for new symptoms. However, the provider follow-up appointment did not occur within five days as required.

### Follow-Up After Transferring into the Institution

Access to care for patients who had recently transferred into the institution was satisfactory. Compliance testing showed staff provided sufficient access to intake appointments for newly arrived patients (MIT 1.002, 76.2%). Case reviewers did not find any deficiencies in this area; however, we only reviewed three cases in which patients transferred from another institution.

### Clinician On-Site Inspection

OIG clinicians attended several morning huddles, which were well-attended by the patient care teams and staff. CMF had eight outpatient or ambulatory care clinics (ACC), facilities one through eight. Seven of the eight clinics had one provider, one registered nurse, and one medical assistant. Three of the seven providers were telemedicine. In addition to its main clinics, CMF operated one TTA, two CTCs, one OHU, one procedure clinic, a specialty clinic for optometry and audiology, and hospice. During huddles, each clinic's office technician reported good access; however, one office assistant reported backlogs due to not having a regular clinic provider until the week prior to our on-site inspection. The office technicians reported scheduling about 10 to 13 appointments for each primary care provider each day.

Our case review clinicians met with the office services supervisor (OSS) and SRN, who managed the appointment scheduling. They reported an office technician vacancy of 80 percent and explained they used medical assistants as office assistants to schedule appointments. The OSS and SRN shared they were "in good shape" regarding backlogs and reported the August rescheduling rate of 20 percent was mostly due to the provider

[15] Urticaria, also known as hives, is an immune response resulting in itchy skin welts.

shortage. When asked about the new provider schedule consisting of four, ten-hour days (in place since July 2023), the OSS reported the transition was going well.

## Compliance Testing Results

### Compliance On-Site Inspection and Discussion

Four of six housing units randomly tested at the time of inspection had access to health care services request forms (MIT 1.101, 66.7 %). In two housing units, the custody officers did not have a system in place for reordering the forms. In one clinic, the custody officers reported relying on medical staff to replenish the health care services request forms in the housing units. In another clinic, the custody officers reported they provided a scanned version of the form saved to the desktop computer and printed more copies when needed. The staff provided copies of the health care services request form rather than procuring original forms from the medical warehouse or custody program offices.

## Compliance Testing Results

### Table 5. Access to Care

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) | 14 | 11 | 0 | 56.0% |
| For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) | 16 | 5 | 4 | 76.2% |
| Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) | 35 | 5 | 0 | 87.5% |
| 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) | 34 | 6 | 0 | 85.0% |
| 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 | 2 | 25 | 86.7% |
| Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) | 1 | 0 | 39 | 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) | 11 | 3 | 0 | 78.6% |
| Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) * | 28 | 14 | 3 | 66.7% |
| Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101) | 4 | 2 | 0 | 66.7% |
| | | | Overall percentage (MIT 1): **78.1%** | |

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

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

## Table 6. Other Tests Related to Access to Care

| | Scored Answer | | | |
|---|---|---|---|---|
| **Compliance Questions** | **Yes** | **No** | **N/A** | **Yes %** |
| For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) | N/A | N/A | N/A | N/A |
| For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004) | N/A | N/A | N/A | N/A |
| Was a written history and physical examination completed within the required time frame? (13.002) | 4 | 0 | 0 | 100% |
| Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) | 10 | 5 | 0 | 66.7% |
| Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) | 8 | 2 | 5 | 80.0% |
| Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) | 8 | 7 | 0 | 53.3% |
| Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) | 5 | 4 | 6 | 55.6% |
| 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) | 10 | 5 | 0 | 66.7% |
| Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) | 4 | 2 | 9 | 66.7% |

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

## *Recommendations*

- Medical leadership should evaluate the root cause(s) of challenges in the timely provision of chronic care follow-up appointments and should implement remedial measures as appropriate.

## Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 7, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Inadequate*** | ***Inadequate* (55.0%)** |

Case review found CMF performed poorly in this indicator. Staff did not always complete laboratory testing or STAT laboratory tests timely. Providers sometimes endorsed laboratory results late. In addition, the providers often did not send complete patient test result notification letters. After reviewing all aspects, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed CRC had mixed results in diagnostic services. CRC showed good performance in providing radiology and routine laboratory services as well as excellent performance in retrieving pathology results. However, staff needed improvement in providing STAT (immediate) laboratory tests, reviewing and endorsing radiology test results, and generating patient test result notification letters with all required key elements. Factoring testing results, the OIG rated the compliance testing component of this indicator ***inadequate***.

### Case Review and Compliance Testing Results

We reviewed 364 diagnostic events and found 166 deficiencies, 11 of which were significant.[16] Of these 166 deficiencies, we found eight related to test completion and 158 related to health information management.

**Test Completion**

CMF performed sufficiently in completing radiology tests. Compliance testing showed the institution completed most radiology tests within the required time frames (MIT 2.001, 80.0%). OIG clinicians reviewed 32 radiology tests and did not find any deficiencies in radiology test completion.

CMF performed satisfactorily in completing laboratory tests. Compliance testing showed the institution completed nearly all laboratory tests within required time frames (MIT 2.004, 90.0%). However, CMF timely completed only half of the STAT laboratory samples

[16] Deficiencies occurred in cases 1–3, 8, 9, 11–15, and 17–29. Significant deficiencies occurred in cases 14, 15, 17, 19, 23, and 28.

during our testing period (MIT 2.007, 50.0%). OIG clinicians reviewed 314 laboratory tests and found eight deficiencies in test completion. The following are examples:

- In case 2, the provider ordered an HIV and a related blood laboratory test, neither of which were completed until 10 days late.

- In case 23, the provider ordered STAT chemistry and complete blood count tests. However, these laboratory tests were collected one day late.

### Health Information Management

Providers performed poorly in their review and endorsement of radiology reports (MIT 2.002, 40.0%) but performed very well in their review and endorsement of laboratory tests (MIT 2.005, 90.0%). Staff always retrieved pathology reports within the required time frames (MIT 2.010, 100%). However, providers needed improvement in reviewing and endorsing the pathology reports in a timely manner (MIT 2.011, 70.0%). Providers did not communicate the results of the pathology studies to the patients within specified time frames (MIT 2.012, zero).

OIG clinicians identified 146 deficiencies.[17] We identified 10 deficiencies involving delays in obtaining timely provider endorsement of the results. The following is an example:

- In case 1, the provider endorsed the chemistry and complete blood count tests results nine days late.

Most deficiencies related to health information management involved incomplete or missing notification letters to patients (140 out of 146 deficiencies). The following are examples:

- In case 19, the provider endorsed urinalysis results but did not generate a patient results notification letter.

- In case 28, the provider endorsed an MRI report but did not generate a patient results notification letter.

### Clinician On-Site Inspection

Case review clinicians interviewed medical leadership, diagnostic supervisors, and providers about diagnostic test procedures and workflows. Laboratory supervisors and providers reported no issues with the timely completion of laboratory tests despite staffing shortages. On-site radiology services included X-ray, ultrasound, computed tomography (CT), and magnetic resonate imaging (MRI). The radiology service experienced a technician vacancy, which resulted in an appointment backlog of X-rays that has since been addressed by bringing in a retired annuitant.

[17] Deficiencies occurred in cases 1–3, 8, 9, 11–15, and 17–29.

## Compliance Testing Results

### Table 7. Diagnostic Services

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) | 8 | 2 | 0 | 80.0% |
| Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) | 4 | 6 | 0 | 40.0% |
| 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 | 10.0% |
| Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) | 9 | 1 | 0 | 90.0% |
| Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) | 9 | 1 | 0 | 90.0% |
| Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006) | 1 | 9 | 0 | 10.0% |
| Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) | 5 | 5 | 0 | 50.0% |
| Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) | 3 | 7 | 0 | 30.0% |
| Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009) | 9 | 1 | 0 | 90.0% |
| Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) | 10 | 0 | 0 | 100% |
| Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) | 7 | 3 | 0 | 70.0% |
| Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012) | 0 | 10 | 0 | 0 |
| | | | | Overall percentage (MIT 2): **55.0%** |

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

## *Recommendations*

- Medical leadership should analyze the root cause(s) of challenges with untimely reviewing and endorsing of radiology and pathology reports and should implement remedial measures as appropriate.

- Medical leadership should analyze the root cause(s) of challenges with untimely collecting, receiving, and notifying providers of STAT laboratory results and should implement remedial measures as appropriate.

- The department should consider developing strategies, such as an electronic solution, to ensure providers generate letters communicating results to their patients and that the letters include all elements as required by policy.

## Emergency Services

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

### *Ratings and Results Overview*

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

CMF's performance in emergency services worsened in this cycle as compared to its performance in Cycle 6. Staff delivered good CPR, and providers delivered satisfactory emergency care. However, nurses needed improvement in nursing assessments, reassessments, and interventions. We identified delays in calling 9-1-1 and provider notification. In addition, we also identified nursing and provider documentation deficiencies; however, these deficiencies did not affect patient care. Considering all factors, we rated this indicator ***inadequate.***

### Case Review Results

We reviewed 34 urgent and emergent events and found 27 emergency care deficiencies. Of these 27 deficiencies, seven were significant.[18]

#### Emergency Medical Response

Our clinicians reviewed 26 emergency medical events that required responses from medical first responders. CMF first responders frequently performed good assessments with documentation and generally intervened when required.[19] Staff responded to medical emergencies promptly, initiated CPR, and notified the TTA within the required time frames. However, we identified an opportunity for improvement in activating EMS immediately. The following case shows a delay in calling 9-1-1:

- In case 24, an emergency alarm was activated for an unconscious patient with a thready pulse.[20] Staff delayed calling 9-1-1 for 28 minutes after the patient was found unconscious. Fortunately, the patient survived and was transported to the hospital for further treatment. During our clinician on-site

[18] We reviewed urgent and emergent events in cases 1–7, 15, 19, and 22–25. Deficiencies occurred in cases 3, 6, 7, 12, 15, 19, and 22–25. Significant deficiencies occurred in cases 3, 7, 12, 24, and 25.

[19] A first responder documentation deficiency occurred in case 24.

[20] A thready pulse is a faint or barely detectable pulse on physical examination.

inspection, nursing leadership agreed with this deficiency and provided training to staff regarding calling 9-1-1 immediately.

### Cardiopulmonary Resuscitation Quality

Our OIG clinicians reviewed four cases involving CPR.[21] In three of the four cases, our clinicians found custody and nursing staff worked together to perform CPR, and nursing staff applied the AED (automated external defibrillator), administered Narcan, and called 9-1-1 immediately. However, we found opportunities for improvement in the following case, showing delays in care:

- In case 7, custody staff activated an alarm for an unresponsive patient who required CPR. However, CMF staff did not call 9-1-1 immediately. We identified a six-minute delay in calling 9-1-1. In addition, we found staff delayed in applying the AED, did not administer naloxone, and inappropriately transferred the patient to the TTA. Instead of moving the patient to the TTA, staff should have continued CPR for the patient at the scene.[22] During our clinician on-site inspection, we spoke with nursing leadership, who agreed with this deficiency and provided training to staff.

### Provider Performance

Providers generally performed well in urgent and emergent situations. They usually made accurate diagnoses; however, we found instances of missing documentation. We identified 12 deficiencies related to emergency care.[23] The following is an example:

- In case 23, the provider ordered antibiotics for a patient who had acute abdominal pain and transferred the patient to the hospital via state vehicle rather than by an ambulance. This placed the patient at increased medical risk because close medical monitoring was needed due to the possibility of a severe abdominal infection.

### Nursing Performance

Although nurses generally responded to emergencies within the required time frame, assessed the patients, and initiated emergency care, we found a pattern of nurses not performing complete assessments and reassessments of abnormal vital signs.[24] The following are examples:

- In case 24, staff activated an emergency alarm for a patient. The patient with a history of hypertension, thyroid problems, and diabetes was found unconscious with a low body temperature and a thready pulse. Staff transported the patient to the TTA for further evaluation, and ultimately the

[21] Patients in cases 4–7 required CPR.

[22] Naloxone is a medication used for the emergency treatment of known or suspected opioid overdose. According to the manufacturer, nasal naloxone doses can be safely administered every two to three minutes. CCHCS emergency medical training allows nurses to administer five nasal naloxone doses when they suspect an opioid overdose has occurred.

[23] Deficiencies occurred in cases 1, 3, 7, 15, 19, and 22–24.

[24] TTA nursing assessment deficiencies occurred in cases 19 and 22–25.

patient was transferred to the community hospital. The TTA RN did not listen to the lung sounds and did not reassess the patient's vital signs, mental status, or oxygenation rate from the time the patient arrived to the TTA until EMS arrived, 24 minutes later.

- In case 25, the TTA nurse evaluated a patient for abdominal pain. The patient had an elevated blood pressure; however, the nurse did not reassess the patient's blood pressure or notify the provider regarding the abnormal finding.

Timely and appropriate nursing interventions are necessary to provide good patient care. The following case illustrates untimely provider notification and an inappropriate intervention:

- In case 24, the nurse administered an oral diabetic medication gel to an unconscious patient, which would have placed the patient at risk for choking.

- Also in case 24, a medical emergency alarm was activated for a patient with confusion. The patient was shivering and wet from urine incontinence. In addition, the patient had a low body temperature, elevated blood pressure, a thready pulse, shallow respirations, and pale skin. Nurses assessed the patient but did not contact the provider until 52 minutes later.

### Nursing Documentation

TTA nurses documented sufficiently for emergent events.[25] We identified deficiencies related to lack of documentation for hospital communication, details of provider co-consult, and times of EMS notification, arrival, and departure. These deficiencies, however, did not significantly affect overall patient care.

### Emergency Medical Response Review Committee

The EMRRC met monthly and reviewed emergency response care within the required time frames. During our review period we found CMF performed clinical reviews for 10 emergency events. They frequently identified deficiencies OIG clinicians found and staff training was provided.[26] The following are exceptions:

- In case 3, the nurse assessed a patient, who had shallow breathing with a fast respiratory rate. However, the nurse did not reassess the patient's vital signs until 42 minutes later.

- In case 25, the nurse assessed a patient, who had stroke-like symptoms of left-sided facial droop, left arm weakness, and decreased verbal response. We identified a 30-minute delay in provider notification for this patient.

[25] TTA nursing documentation deficiencies occurred in cases 3, 15, 19, 22, and 24.

[26] CMF performed clinical reviews of emergency events in cases 3–7, 15, 24, and 25. EMRRC or clinical reviewers did not identify deficiencies that OIG clinicians identified in cases 3, 7, and 25.

Compliance testing showed poor performance with the EMRRC. Testing revealed incomplete emergency medical response and unscheduled transport event checklists, untimely reviews, and incomplete reviews by the chief medical executive (CME) and chief nurse executive (CNE) (MIT 15.003, 41.7%). Our case reviewers found two cases in which the CME and CNE did not complete clinical reviews of the emergency event.[27]

### Clinician On-Site Inspection

At the on-site inspection, OIG clinicians toured the TTA and spoke with staff and nursing leadership. The TTA contained five beds, including one isolation bed. Staff consisted of two RNs on first watch, and three RNs on second and third watch. On first watch, the receiving and release (R&R) RN was the backup nurse for the TTA. The TTA SRN reported the TTA has two allocated RN positions for each watch and a third RN is assigned if available. The TTA has a regular provider assigned to the TTA during business hours, while an on-call provider is available after hours.

The TTA staff reported having an Omnicell, which contains medications, and the pharmacist is available on call as needed.[28] They also reported they have a new supply system and order supplies weekly. The TTA staff reported staffing is challenging, nursing morale is fair, and custody staff is reliable.

Nursing leadership reported initiating a nursing quality improvement project in January 2023, which includes training to recognize an emergency and calling 9-1-1 without delay. Nursing leadership reported significant improvement. Two weeks prior to our on-site inspection, nursing leadership initiated another project to improve 9-1-1 activation, as TTA nurses were provided two cell phones to utilize.

[27] The CME and CNE did not complete a clinical review of the emergency events for cases 6 and 7.

[28] An Omnicell is an automated medication dispensing machine.

## *Recommendations*

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

- Nursing leadership should ensure nursing supervisors are trained on thoroughly completing the emergency medical response review checklist. In addition, nursing and medical leadership should audit CMF's emergency events to identify any opportunities for improvement with providers and nurses.

## Health Information Management

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

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Inadequate*** | ***Inadequate* (70.9%)** |

Case review found CMF performed poorly overall in managing health information. Staff had problems with managing specialty reports and providers did not always endorse test reports timely. In addition, providers did not consistently generate complete patient test result notification letters with all required components per CCHCS policy. After careful consideration, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed CMF had a mixed performance in this indicator. Staff performed satisfactorily in scanning patient sick call requests as well as retrieving and scanning hospital records. However, they performed poorly in endorsing hospital reports and labeling and scanning medical records. Taking all results into consideration, the OIG rated the compliance testing component of this indicator ***inadequate.***

### Case Review and Compliance Results

We reviewed 347 events and found 207 deficiencies related to health information management. Of these 207 deficiencies, 22 were significant.[29]

#### Hospital Discharge Reports

CMF staff performed sufficiently in retrieving and scanning hospital discharge documents into patients' electronic health records within required time frames (MIT 4.003, 78.6%). CMF sometimes obtained hospital discharge reports with key elements and providers reviewed them within the required time frame (MIT 4.005, 64.3%). The OIG clinicians reviewed 98 off-site emergency department and hospital encounters and identified 10 deficiencies.[30] The following are examples of delayed scanning of hospital records:

[29] Deficiencies occurred in cases 1–3, 8, 9, 11–15, 17–29. Significant deficiencies occurred in cases 13, 12, 14, 15, 17, 19, 22, 23, and 28.

[30] Deficiencies occurred in cases 1–3, 12, 15, 22, and 23.

- In case 12, staff scanned the hospital emergency department records into the electronic health record 18 days after the patient was discharged.

- In case 22, staff scanned the hospital emergency department records into the electronic health record 10 days after the patient was discharged.

### Specialty Reports

CMF performed poorly in managing specialty reports. CMF scored low in retrieving and reviewing the high-priority, medium-priority, and routine-priority specialty reports within the required time frames (MIT 14.002, 26.7%; MIT 14.005, 20.0%; and MIT 14.008, 21.4%). In addition, staff needed improvement in scanning the specialty reports within the required time frame (MIT 4.002, 53.3%). Our clinicians reviewed 122 specialty reports and identified 44 deficiencies.[31] The following are examples:

- In case 17, the provider endorsed an ophthalmology specialty report 15 days after the report was available.

- In case 22, an oral surgery specialist evaluated the patient. However, staff did not scan the specialist's report into the electronic health record.

### Diagnostic Reports

Compliance testing showed providers endorsed nearly all laboratory reports timely (MIT 2.005, 90.0%) but endorsed less than half of radiology reports timely (MIT 2.002, 40.0%). Our clinicians identified eight deficiencies lacking timely endorsements tests and 140 deficiencies with missing or incomplete patient test result letters.

CMF always retrieved pathology reports timely (MIT 2.010, 100%). Providers endorsed the majority of pathology reports within the required time frames (MIT 2.011, 70.0%) but did not send pathology result letters to their patients within the required time frames (MIT 2.012, zero). Our clinicians reviewed three events associated with pathology reports and only found one deficiency.

### Urgent and Emergent Records

OIG clinicians reviewed 34 emergency care events and found both nurses and providers generally recorded these events sufficiently. The **Emergency Services** indicator provides additional details.

### Scanning Performance

CMF staff had a mixed performance with the scanning process. Compliance testing showed staff needed improvement with scanned medical files (MIT 4.004, 58.3%). However, OIG clinicians found only two deficiencies with mislabeled documents.

[31] Deficiencies occurred in cases 1, 11, 12, 14, 15, 17, 22, 23, and 25–29.

### Clinician On-Site Inspection

At the on-site inspection, OIG clinicians interviewed health care leadership, health information management supervisors, providers, nurses, and ancillary staff. Health information management supervisors reported HRT staffing shortages but did not report significant issues in retrieving reports. Executive leadership reported two office assistant vacancies.

## Compliance Testing Results

### Table 8. Health Information Management

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001) | 20 | 0 | 20 | 100% |
| Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) | 16 | 14 | 15 | 53.3% |
| Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) | 11 | 3 | 0 | 78.6% |
| During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) | 14 | 10 | 0 | 58.3% |
| 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) | 9 | 5 | 0 | 64.3% |
| | | | | Overall percentage (MIT 4): **70.9%** |

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

## Table 9. Other Tests Related to Health Information Management

| | Scored Answer | | | |
|---|---|---|---|---|
| **Compliance Questions** | **Yes** | **No** | **N/A** | **Yes %** |
| Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) | 4 | 6 | 0 | 40.0% |
| Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) | 9 | 1 | 0 | 90.0% |
| Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) | 3 | 7 | 0 | 30.0% |
| Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) | 10 | 0 | 0 | 100.0% |
| Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) | 7 | 3 | 0 | 70.0% |
| Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012) | 0 | 10 | 0 | 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) | 4 | 11 | 0 | 26.7% |
| Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) | 3 | 12 | 0 | 20.0% |
| Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) | 3 | 11 | 1 | 21.4% |

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

## *Recommendations*

- Medical leadership should evaluate challenges to ensuring documents, including specialty documents and hospital discharge reports, are properly scanned and labeled in the electronic health record as required by CCHCS policy and should implement remedial measures as appropriate.

- Medical leadership should evaluate challenges to providers timely reviewing hospital discharge reports and should implement remedial measures as appropriate.

## Health Care Environment

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

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Not Applicable*** | ***Inadequate* (63.1%)** |

Overall, CMF's health care environment needed improvement. Although staff maintained some aspects of infection control and clinic areas to provide medical services, multiple other aspects were poor: medical supplies storage areas inside of the clinics either contained expired medical supplies, compromised sterile medical supply packaging, or medical supplies stored with staff's personal items or food; several areas of the examination rooms and staff restroom were unsanitary; emergency medical response bag (EMRB) logs were missing staff verification or inventory was not performed; several clinics did not meet the requirements for essential core medical equipment and supplies; and staff did not regularly sanitize their hands before and after examining patients. Considering all factors, the OIG rated this indicator ***inadequate***.

### Compliance Testing Results

#### Patient Waiting Areas

We inspected only indoor waiting areas as CMF had no outdoor waiting areas (see Photo 1). Health care and custody staff reported existing waiting areas contained sufficient seating capacity. During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.


Photo 1. Indoor waiting area (photographed on 6-8-23).

### Clinic Environment

Of the 14 applicable clinics we observed, 13 provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 92.9%). In one clinic, the triage station was within close proximity to the patients' bunk beds, which hindered auditory privacy.

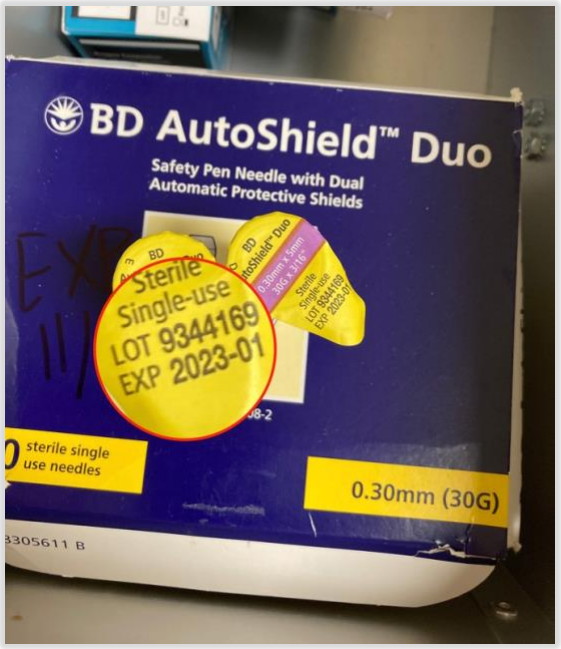


Photo 2. Expired medical supplies dated January 2023 (photographed on 6-6-23).

All clinic environments contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 100%).

### Clinic Supplies

Seven of 18 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 38.9%). We found one or more of the following deficiencies in 11 clinics: expired medical supplies (see Photo 2), unidentified or inaccurately labeled medical supplies, compromised original medical supply packaging, medical supplies stored directly on the floor, staff members' personal items and food stored with medical supplies (see Photo 3), and cleaning materials stored with medical supplies.

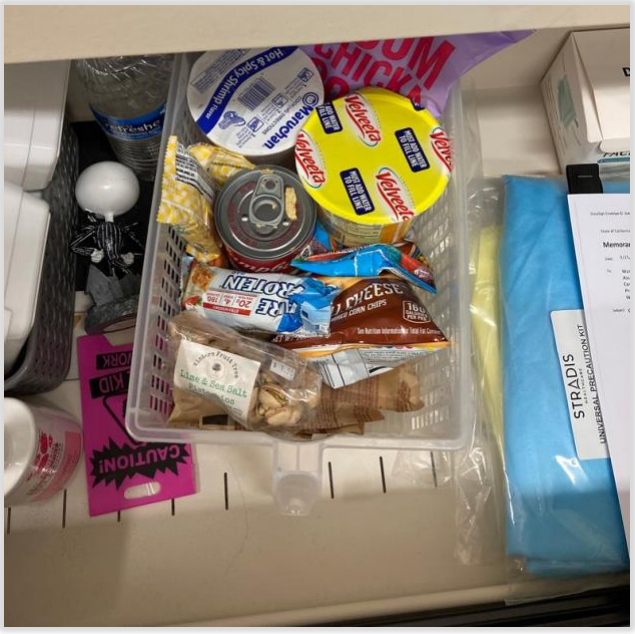


Photo 3. Staff members' personal items and food stored with medical supplies (photographed on 6-8-23).

Of the 18 clinics we observed, 11 met requirements for essential core medical equipment and supplies (MIT 5.108, 61.1%). The remaining seven clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included a glucometer and medication refrigerator. Staff had not properly calibrated a nebulization unit. We found a nonfunctional ophthalmoscope and overhead light. In one clinic, although the automated external defibrillator (AED) was available at the time of inspection, the log indicated the clinic was missing an AED for the previous 30 days. In addition, staff did not complete the AED performance test log documentations within the last 30 days, and a clinic daily glucometer quality control log was inaccurate.

We examined EMRBs to determine if they contained all essential items. We checked if staff inspected the bags daily and inventoried them monthly. Only five of the 11 applicable EMRBs passed our test (MIT 5.111, 45.5%). We found one or both of the following deficiencies with six EMRBs: staff failed to ensure the EMRB compartments were sealed and intact, and staff had not inventoried the EMRBs when seal tags were replaced. In addition, the correctional treatment center (CTC) housing units were missing treatment carts at the time of our inspection.

### Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). The warehouse manager did not maintain a temperature log for medical supplies with manufacturer temperature guidelines stored in the medical warehouse. We found several intravenous solutions accumulated condensation (see Photo 4).

Photo 4. Several intravenous solutions had accumulated condensation (photographed on 6-7-23).

### Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected six of 13 applicable clinics (MIT 5.101, 46.2%). In seven clinics, we found one or more of the following deficiencies: examination room cabinets and floors, a staff restroom, and a gurney were unsanitary; and cleaning logs were not maintained.

Staff in 12 of 16 applicable clinics (MIT 5.102, 75.0%) properly sterilized or disinfected medical equipment. In four clinics, staff did not mention disinfecting the examination table as part of their daily start-up protocol.

We found operating sinks and hand hygiene supplies in the examination rooms of 16 of 18 clinics (MIT 5.103, 88.9%). In one clinic, the patient restroom lacked antiseptic soap. In another clinic, the patient restroom lacked antiseptic soap and disposable hand towels.

We observed patient encounters in 11 applicable clinics. In six clinics, clinicians did not wash their hands before or after examining their patients (MIT 5.104, 45.5%).

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

### Physical Infrastructure

At the time of the compliance inspection, CMF did not have any ongoing health care facility improvement program (HCFIP) projects. However, the plant operations manager expressed their concern with the U-Wing medication distribution room (MDR) having an ongoing leak issue (see Photo 5 (this page), and Photos 6 and 7 (next page)). The manager reported the leak will be an ongoing issue due to the building having been built in 1955. As such, the pipes are old, and finding the correct parts is challenging. As a result, when they patch a leak, another leak occurs in a different area of the MDR. The manager recommended that a MDR should not be placed in the affected area. During the interview with the chief nursing executive (CNE), he reported he was not apprised of the plant operation manager's concern of the MDR placement in the U-Wing location. The CNE reported he will communicate with the plant operation manager and chief executive officer (CEO) to determine a solution (MIT 5.999).

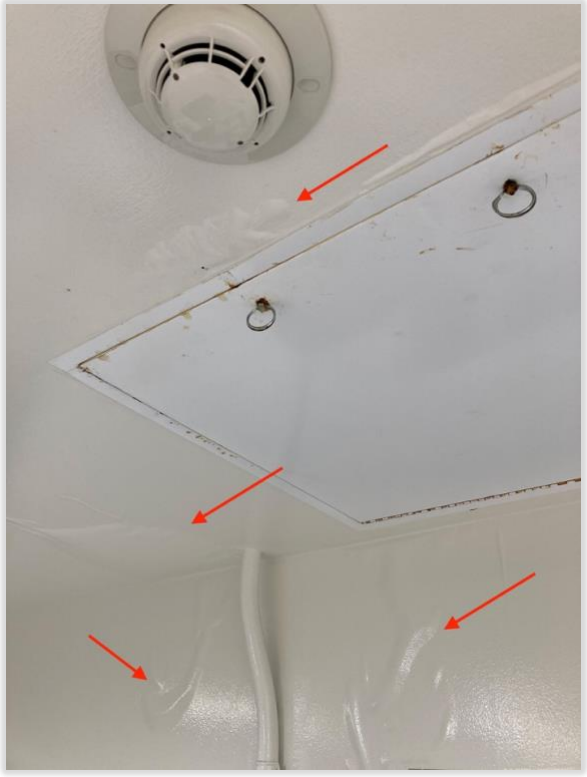

Photo 5. Medication distribution room with ongoing water leak issues (photographed on 6-6-23).

Photo 6. Medication distribution room with ongoing water leak issues (photographed on 6-6-23).

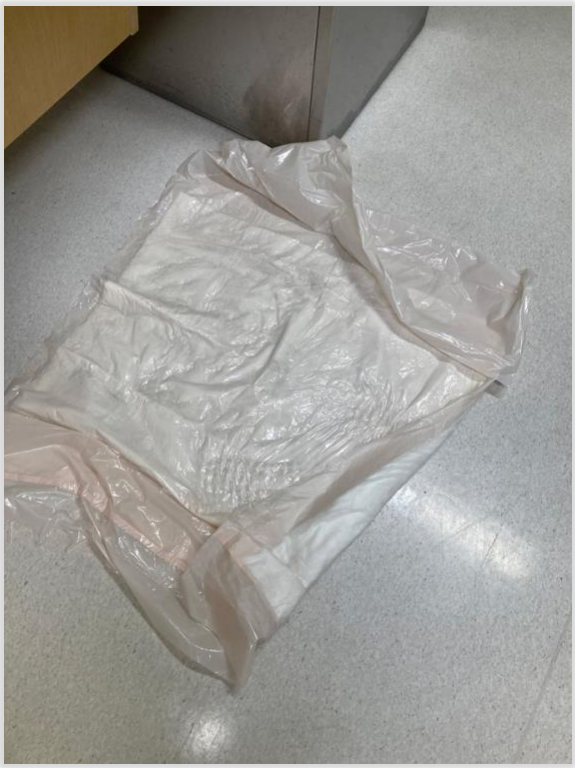

Photo 7. Medication distribution room with ongoing water leak issues (photographed on 6-6-23).

## Compliance Testing Results

### Table 10. Health Care Environment

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101) | 6 | 7 | 5 | 46.2% |
| Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102) | 12 | 4 | 2 | 75.0% |
| Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103) | 16 | 2 | 0 | 88.9% |
| Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104) | 5 | 6 | 7 | 45.5% |
| Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105) | 18 | 0 | 0 | 100% |
| Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106) | 0 | 1 | 0 | 0 |
| Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107) | 7 | 11 | 0 | 38.9% |
| Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108) | 11 | 7 | 0 | 61.1% |
| Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109) | 13 | 1 | 4 | 92.9% |
| Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110) | 18 | 0 | 0 | 100% |
| 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) | 5 | 6 | 7 | 45.5% |
| 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): **63.1%** |

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

## *Recommendations*

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

- Executive leadership should analyze the root cause(s) for staff not ensuring medical supply storage areas, located inside and outside the clinics, store medical supplies properly and should implement remedial measures as appropriate.

- Nursing leadership should analyze the root cause(s) for staff not ensuring clinic examination rooms contain calibrated functional essential core medical equipment and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the emergency medical response bags (EMRBs) are regularly inventoried and sealed or failing to properly complete the monthly logs and should implement remedial measures as appropriate.

## Transfers

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

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Adequate*** | ***Inadequate*** **(55.8%)** |

Case review found CMF performed sufficiently in this indicator. In the transfer-in process, we did not identify any deficiencies in completing timely provider follow-up appointments. We also found the transfer-out process was generally satisfactory. CMF nurses frequently performed thorough assessments when patients returned from the hospital. However, nurses did not always document or communicate pending specialty appointments or referrals to the receiving institution. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed mixed CMF performance. CMF staff performed satisfactory in timely provider follow-ups for patients transferring into the institution and returning from the hospital. However, compliance testing showed low scores for initial nurse screening, medication continuity, and pending specialty appointments. In addition, compliance testing showed poor performance with continuity of hospital-recommended medications, and providers frequently did not review hospital reports within the required time frame. After factoring the testing results, the OIG rated the compliance testing component of this indicator ***inadequate***.

## Case Review and Compliance Testing Results

We reviewed 38 events in 17 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room.[32] We identified 18 deficiencies, four of which were significant.[33]

### Transfers In

CMF's performance for the transfer-in process varied. Compliance testing found nurses always completed the assessment and disposition section on the initial health screening form (MIT 6.002, 100%). Our case review clinicians found nurses almost always completed required screening, scheduled required provider and nurse appointments, and ensured medication reconciliation. Our clinicians reviewed six events in three cases in which patients transferred into the facility from other institutions and found one documentation deficiency.[34]

Conversely, aside from the compliance testing result described above, compliance results were mostly poor. Specifically, CMF nurses sporadically documented an explanation for "Yes" answers on the initial health screening form (MIT 6.001, 20.0%). In addition, CMF sometimes ensured medication continuity when patients arrived at the institution (MIT 6.003, 47.4%), when patients transferred from yard to yard within the institution (MIT 7.005, 48.0%), or when patients were en route during a layover (MIT 7.006, 30.0%). Patients who arrived at CMF with approved specialty appointments were sporadically scheduled within the required time frames (MIT 14.010, 30.0%).

Compliance findings showed the institution performed sufficiently in timely completing provider follow-up appointments for newly arrived patients (MIT 1.002, 76.2%). OIG clinicians did not identify any deficiencies for initial provider appointments.

### Transfers Out

CMF's performance for the transfer-out process was satisfactory. Performance in this area was based mainly on case review findings as compliance testing did not have patients transferring out during the week of the on-site inspection (MIT 6.101, N/A). Our case review clinicians reviewed six events in three cases and identified two deficiencies.[35] CMF's Receiving and Release (R&R) nurses completed the transfer packets and ensured the patients had all durable medical equipment (DME) and medications. However, the nurses did not always document or communicate pending specialty referrals or appointments to the receiving facility.

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[32] We reviewed cases 1–3, 10, 12, 13, 15, 22–25, 27, and 30–35.

[33] Deficiencies occurred in cases 1–3, 15, 22–25, 31, 33, and 34. Significant deficiencies occurred in cases 3 and 23. The significant deficiencies were related to medication management and HIM.

[34] We reviewed cases 30–32 for patients who arrived at CMF from another institution. A documentation deficiency occurred in case 31, which did not affect patient care.

[35] Cases 33–35 included patients who transferred out of CMF. Deficiencies for patients who transferred out of CMF occurred in cases 33 and 34.

### Hospitalizations

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

Our case review clinicians reviewed 11 cases with 26 events.[36] We identified 15 deficiencies, four of which were significant.[37] Nurses frequently performed thorough assessments when patients returned from the hospital.[38] Of the 15 deficiencies, two related to nursing performance, four to medication management, and nine to health information management. Nursing performance did not have any significant deficiencies.

Compliance findings showed poor continuity of hospital-recommended medications (MIT 7.003, 7.7%). Case review identified a pattern of deficiencies in which medications were not available to patients after a hospital return.[39] The following is a significant deficiency:

- In case 3, the provider ordered vancomycin, an antibiotic, to be administered every six hours for 14 days for a patient who had severe pneumonia. On the following day, the medication administration documentation stated, "Not done, medication not available."

Our case review clinicians did not identify any deficiencies with the provider follow-up appointments for patients after hospital discharge. Compliance testing results were also satisfactory (MIT 1.007, 78.6%). Staff usually scanned hospital discharge documents within the required time frame (MIT 4.003, 78.6%). However, providers only sometimes reviewed hospital documents within the required time frame (MIT 4.005, 64.3%). Please refer to the **Health Information Management indicator** for additional discussion.

### Clinician On-Site Inspection

OIG clinicians toured the R&R area, which consisted of one examination room and a separate interview room. The clean and organized area contained a green emergency response bag. The R&R nurse was knowledgeable about the transfer processes. This area was staffed with one RN on each watch. The nurse on first watch assisted staff in the TTA if the nurse did not have patient arrivals. We were informed one to 24 patients arrive at CMF daily, and an average of four patients transfer out daily. R&R staff reported no problems with supplies or equipment. However, R&R staff stated one current challenge

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[36] Patients returned from a hospitalization or emergency room visit in cases 1–3, 10, 12, 15, 22–25, and 27.

[37] Hospitalization deficiencies occurred in cases 1–3, 15, and 22–25. Cases 3 and 23 had significant deficiencies. Two deficiencies were related to nursing performance, four to pharmacy and medication management, and nine to HIM.

[38] Case review identified two nursing performance deficiencies for hospitalizations in cases 22 and 25. One was related to documentation and the other was related an incomplete skin assessment and initiation of a care plan.

[39] Medications were not available in cases 3, 23, and 24. Essential medications included Lasix, Atorvastatin, Mometasone, and Valproic acid. Lasix is a diuretic blood pressure medication. Atorvastatin is a cholesterol lowering medication. Mometasone is a steroid medication. Valproic acid is an antiseizure medication that is also used for bipolar disorder and migraine prevention.

was the process to obtain medications for patients who are paroling or transferring out of CMF. The R&R nurses reported needing to go to the pharmacy to pick up medications for these patients rather than the pharmacy delivering the medications to R&R. The R&R nurse reported fair nursing morale, an approachable supervisor, and a good rapport with custody staff.

## Compliance Testing Results

### Table 11. Transfers

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) | 5 | 20 | 0 | 20.0% |
| For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002) | 24 | 0 | 1 | 100% |
| For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) | 9 | 10 | 6 | 47.4% |
| For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) | N/A | N/A | N/A | N/A |
| | | | | Overall percentage (MIT 6): **55.8%** |

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

## Table 12. Other Tests Related to Transfers

| | Scored Answer | | | |
|---|---|---|---|---|
| **Compliance Questions** | **Yes** | **No** | **N/A** | **Yes %** |
| For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) | 16 | 5 | 4 | 76.2% |
| 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) | 11 | 3 | 0 | 78.6% |
| Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) | 11 | 3 | 0 | 78.6% |
| 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) | 9 | 5 | 0 | 64.3% |
| Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) | 1 | 12 | 1 | 7.7% |
| Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) | 12 | 13 | 0 | 48.0% |
| For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) | 3 | 7 | 0 | 30.0% |
| For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) | 6 | 14 | 0 | 30.0% |

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

## *Recommendations*

- The department should analyze the challenges to ensuring R&R nurses properly and thoroughly complete initial health screening questions and follow up as needed and should implement remedial measures as appropriate.

- Nursing leadership should analyze the challenges for nurses in documenting pending specialty referrals for patients transferring to other institutions and should implement remedial measures as appropriate.

## Medication Management

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

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Adequate*** | ***Inadequate* (53.4%)** |

Case Review found CMF's performance for this indicator was satisfactory. We found staff always maintained medication continuity when patients arrived at or transferred out of CMF. Patients frequently received their newly prescribed medications and hospital discharge medications timely. However, we identified opportunities for improvement with new medication prescriptions, chronic medication continuity, and specialized medical housing medications. Factoring in all the information, OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed CMF needed improvement in this indicator. While staff performed well with general security in its main pharmacy, staff needed to improve with chronic medication continuity, newly prescribed medications, and hospital discharge medications as well as with patients who were transferring within the institution or temporarily housed in CMF. Considering the test results, the OIG rated the compliance testing component of this indicator ***inadequate.***

### Case Review and Compliance Testing Results

We reviewed 155 events in 31 cases related to medications and found 36 medication deficiencies, eight of which were significant.[40] Our case review findings showed CMF made some improvement in medication management this cycle.[41]

#### New Medication Prescriptions

CMF's performance with new medications varied. Compliance findings showed more than half of the new prescriptions were administered timely (MIT 7.002, 60.0%). Essential medications such as blood pressure and antibiotic medications were provided one to four doses late. Other medications were given one dose to 60 doses late. OIG clinicians

[40] We reviewed case 1–3, and 8–35 for medication management. Deficiencies occurred in cases 1-3, 8, 9, 13–16, 18, 20–25, 28, and 39. Significant deficiencies occurred in cases 3, 14–16, 21, and 25.

[41] In Cycle 6, we reviewed 146 medication events and found 52 deficiencies of which 36 were significant.

identified four deficiencies related to new medications, none of which were significant. One deficiency related to documentation while the others related to medications, such as creams and a topical pain patch.[42]

### Chronic Medication Continuity

CMF also had mixed results for chronic medication continuity. Compliance testing showed a very low score for chronic medication continuity (MIT 7.001, 4.4%). The low score was mostly due to patients not receiving their keep-on-person medications one business day before the prescription exhausted as well as with the pharmacy not filling and dispensing medications timely. In addition, nurses did not always document the reason why patients refused medications or the reasons why patients did not show up to receive their medications. Our clinicians identified 11 deficiencies, five of which were significant.[43] In a few cases, we found patients with chronic medication either did not receive the medications timely or did not receive the medications at all. The following cases are examples of significant deficiencies:

- In case 14, during the month of January 2023, the patient did not receive his chronic care medication, aspirin. Per the medication administration record, the medication was not available.

- In case 15, for the month of January 2023, the patient did not receive chronic care medications for high blood pressure and glaucoma.[44]

### Hospital Discharge Medications

Compliance testing showed CMF performed very poorly for patients receiving their discharge medications upon return from off-site hospitalizations (MIT 7.003, 7.7%). Medications were provided one to 30 doses late and included medications for cholesterol, high blood pressure, acid reflux, and asthma. In contrast, our clinicians reviewed 26 events in which patients returned from a hospital and identified four deficiencies, only one of which was significant. Please refer to the **Transfers** indicator for additional details.

### Specialized Medical Housing Medications

Compliance testing showed medications were not made available or administered to Specialized Medical Housing (SMH) patients in the required time frames (MIT 13.003, 25.0%). Our clinicians identified 11 deficiencies, two of which were significant. Patients in the SMH did not always receive their medications as ordered and, in some cases, medications were not available.[45] Please refer to the **Specialized Medical Housing** indicator for additional information.

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[42] New medication deficiencies occurred in cases 20, 23, 28, and 39.

[43] Deficiencies for chronic care medications occurred in cases 2, 13–16, 21, and 23. Significant deficiencies occurred in cases 14–16 and 21.

[44] The high blood pressure medications are amlodipine and losartan. The glaucoma medication was latanoprost.

[45] SMH patients did not always receive their medications as ordered in cases 1–3, 24, and 25. Some medications were not available in cases 3, 9, 22, and 24.

### Transfer Medications

Compliance testing showed CMF sporadically ensured continuity of medications for patients who transferred into the institution (MIT 6.003, 47.4%). Similarly, when patients transferred from yard to yard, they only occasionally received their medications without interruption (MIT 7.005, 48.0%). In addition, CMF performed poorly in ensuring patients en route to another institution received their medications without interruption (MIT 7.006, 30.0%). Our clinicians did not identify any medication deficiencies for patients who transferred into or out of CMF.

### Medication Administration

Compliance testing showed nurses needed improvement in administering TB medications within the required time frame (MIT 9.001, 60.0%). The low score resulted from nurses not documenting patients' reasons for medication refusal and not showing up to the medication line. In addition, nurses occasionally monitored patients taking TB medications (MIT 9.002, 20.0%).

### Clinician On-Site Inspection

During our on-site inspection, we toured the CTC and outpatient medication rooms, where we interviewed the medication nurses. In the CTC, each shift had an assigned medication LVN, who attends the daily huddles and communicates medication concerns to the provider. The CTC's medication LVN reported the pharmacy restocks patient medications three times a week, while special medications and narcotics are stocked as needed. These LVNs also participate in providing emergency care in the CTC. The CTC has a board with assigned roles for each nurse.

CMF has a designated medication room for the outpatient area which has four Omnicells and multiple medication carts. The Omnicells contain narcotics and special medications, such as the hepatitis medication, Epclusa. During discussions with the medication LVNs, we found them knowledgeable about medication processes. The medication LVNs stock their carts and distribute medications to different buildings. The outpatient medication LVNs communicate medication concerns to the outpatient registered nurse or provider via phone. They are not assigned to respond to emergencies but assist if they are present during an emergency. Outpatient LVN staff did not report any issues with supplies or equipment; however, they reported issues with the untimely delivery of keep-on-person medications during the last month of the clinician on-site inspection.

We also interviewed an SRN who supervises the outpatient medication staff. The SRN reported current nursing quality improvement projects include medication safety and monitoring refusals. One of the projects includes monitoring nursing staff to ensure they document narcotic waste. Another project includes working with custody staff to ensure patients, who have family visits, receive ordered medications timely. The SRN reported the challenge of Suboxone not always being available on Mondays, which was discussed with the pharmacist.[46]

[46] Suboxone is a medication containing buprenorphine and naloxone. Suboxone is used to treat opioid dependence and addiction.

We interviewed staff, who reported a good working relationship with custody staff and felt their supervisors were approachable.

## Compliance Testing Results

### Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in 11 of 13 applicable clinic and medication line locations (MIT 7.101, 84.7%). In one location, we identified discrepancies in the Omnicell physical count of the narcotic medication at the time of our inspection. In the remaining clinic, narcotic medications were not properly securely stored as required by CCHCS policy.

CMF appropriately stored and secured nonnarcotic medications in 11 of 16 applicable clinic and medication line locations (MIT 7.102, 68.8%). In five locations, we observed one or more of the following deficiencies: several medications stored beyond the prescription's expiration date rather than being returned to the pharmacy; unissued medications not maintained in their original labeled packaging; and incomplete daily security check treatment cart log entries.

Staff kept medications protected from physical, chemical, and temperature contamination in 11 of the 16 applicable clinic and medication line locations (MIT 7.103, 68.8%). In five locations, we found one or more of the following deficiencies: staff did not store oral and topical medications separately; the medication refrigerator was unsanitary; and several temperature readings within the previous 30 days were not kept within the manufacturer temperature guidelines.

Staff successfully stored valid, unexpired medications in 15 of the 16 applicable medication line locations (MIT 7.104, 93.8%). In one location, nurses did not label the multi-use medication as required by CCHCS policy.

Nurses performed proper hand hygiene and contamination control protocols in four of six applicable locations (MIT 7.105, 66.7%). In two locations, some nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in all medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 100%).

Staff in four of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 66.7%). In one location, medication nurses did not distribute medications to patients within the required time frame, and medication nurses did not reliably observe patients while the patients swallowed direct observation therapy medications. In the remaining location, during insulin administration, we observed some medication nurses did not properly disinfect the vial's port prior to withdrawing medication.

### Pharmacy Protocols

CMF followed general security, organization, and cleanliness management protocols for nonrefrigerated medications stored in both pharmacies (MITs 7.108 and 7.109, 100%).

The institution did not properly store refrigerated or frozen medications in either pharmacy (MIT 7.110, zero). In the main pharmacy, the medication refrigerator was disorganized, and several temperature readings within the previous 30 days were not kept within the manufacturer temperature guidelines. The remote pharmacy did not have an identifiable designated area for refrigerated medications returned to the pharmacy.

The pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. In two locations, we found the following deficiencies: the monthly inventory was not performed by the PIC or a pharmacist but was instead completed by a pharmacy technician; the PIC did not sign and date a medication area inspection checklist (CDCR Form 7477); and the PIC did not investigate or report a discrepancy of the narcotic inventory for one medication area inspected. These errors resulted in a very poor score for this test (MIT 7.111, zero).

We examined 24 medication error reports. The PIC timely or correctly processed only two of these 24 reports (MIT 7.112, 8.3%). In 22 reports, we found one or more of the following deficiencies: explanation was missing for not notifying the provider and patient; the PIC did not document the contributing causes of the error; the PIC did not document the recommended changes to correct the errors from occurring in the future; and the PIC did not complete the medication follow-up form timely.

### Nonscored Tests

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

At the time of our inspection, CMF did not have a dedicated restrictive housing unit (MIT 7.999).

## Compliance Testing Results

### Table 13. Medication Management

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) | 1 | 22 | 2 | 4.4% |
| Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002) | 15 | 10 | 0 | 60.0% |
| Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) | 1 | 12 | 1 | 7.7% |
| For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) | N/A | N/A | N/A | N/A |
| Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) | 12 | 13 | 0 | 48.0% |
| For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) | 3 | 7 | 0 | 30.0% |
| All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101) | 11 | 2 | 5 | 84.6% |
| 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) | 11 | 5 | 2 | 68.8% |
| 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) | 11 | 5 | 2 | 68.8% |
| 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) | 15 | 1 | 2 | 93.8% |
| Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105) | 4 | 2 | 12 | 66.7% |
| Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106) | 6 | 0 | 12 | 100% |
| Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107) | 4 | 2 | 12 | 66.7% |
| Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108) | 2 | 0 | 0 | 100% |
| Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109) | 2 | 0 | 0 | 100% |
| Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110) | 0 | 2 | 0 | 0 |
| Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111) | 0 | 1 | 1 | 0 |
| Pharmacy: Does the institution follow key medication error reporting protocols? (7.112) | 2 | 22 | 0 | 8.3% |
| Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998) | This is a nonscored test. Please see the indicator for discussion of this test. | | | |
| Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999) | This is a nonscored test. Please see the indicator for discussion of this test. | | | |
| | | | | Overall percentage (MIT 7): **53.4%** |

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

## Table 14. Other Tests Related to Specialized Services

| | Scored Answer | | | |
|---|---|---|---|---|
| **Compliance Questions** | **Yes** | **No** | **N/A** | **Yes %** |
| For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) | 9 | 10 | 6 | 47.4% |
| For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) | N/A | N/A | N/A | N/A |
| Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) | 3 | 2 | 0 | 60.0% |
| Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) | 1 | 4 | 0 | 20.0% |
| Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003) | 1 | 3 | 0 | 25.0% |

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

## *Recommendations*

- The institution should determine the root cause(s) of challenges to ensuring staff timely make available and administer medications to patients, and staff document the electronic health record as described in CCHCS policy and procedures and should implement remedial measures as appropriate.

## Preventive Services

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

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Not Applicable*** | ***Inadequate* (69.2%)** |

CMF had a mixed performance in this indicator. Staff performed well in screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. However, staff needed improvement in administering TB medications to patients, poorly monitoring patients on TB medications, and sporadically offering required immunizations to chronic care patients. The OIG rated this indicator ***inadequate***.

## Compliance Testing Results

### Table 15. Preventive Services

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) | 3 | 2 | 0 | 60.0% |
| Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) | 1 | 4 | 0 | 20.0% |
| Annual TB screening: Was the patient screened for TB within the last year? (9.003) | 24 | 1 | 0 | 96.0% |
| Were all patients offered an influenza vaccination for the most recent influenza season? (9.004) | 23 | 2 | 0 | 92.0% |
| All patients from the age of 45 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) | 8 | 9 | 8 | 47.1% |
| 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): **69.2%** |

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

## *Recommendations*

- Nursing leadership should consider developing and implementing measures to ensure nursing staff documents on the MAR summaries patient refusals and no-shows in accordance with CCHCS' policies and procedures.

- Nursing leadership should consider analyzing the challenges in ensuring nursing staff monitor and address symptoms of patients receiving TB medications according to CCHCS guidelines and should implement remedial measures as appropriate.

- Medical leadership should analyze the challenges related to the untimely provision of preventive vaccines to chronic care patients and should implement remedial measures as appropriate.

## Nursing Performance

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

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

### *Ratings and Results Overview*

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

Although compared with Cycle 6, we identified fewer nursing deficiencies, CMF nurses needed improvement in several areas. Nurses in emergency services, specialized medical housing, and the outpatient clinics struggled with providing complete, thorough nursing assessments and interventions. However, nursing performance during the transfer process and in nursing documentation were satisfactory. Carefully considering all factors in the quality of nursing care, the OIG rated this indicator ***inadequate***.

### Case Review Results

We reviewed 303 nursing encounters in 60 cases and identified 79 nursing performance deficiencies, 18 of which were significant.[47]

#### Outpatient Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements. A comprehensive assessment allows nurses to gather essential information about their patients and develop appropriate interventions.

Our clinicians found opportunities for improvement with incomplete patient assessment and untimely interventions. Cycle 6 had similar findings. In Cycle 7, 98 of the nursing

[47] Deficiencies occurred in cases 1 to 3, 8, 10, 15, 17, 19, 21 to 25, 29, 31, 33, 34, 36 to 38, 40, 42–48, 50, 52 to 55, 57, and 59–62. Significant deficiencies occurred in cases 2, 3, 19, 23, 24, 25, 50, 53, 53, 57, and 59.

encounters occurred in the outpatient setting, 52 of which were sick call requests. Our clinicians identified 34 outpatient deficiencies, 11 of which were significant.[48] We identified a pattern of incomplete assessments during face-to-face encounters, improper triage of sick calls, and a lack of co-consults with providers.[49] In addition, nurses did not always perform complete assessments for patient complaints or reassess abnormal vital signs. The following are examples of significant deficiencies:

- In case 23, the patient submitted a sick call request for symptoms of difficulty breathing, joint pain, numbness, tingling, and headaches. The nurse triaged the sick call as asymptomatic, which was in error, and did not perform a patient assessment.

- On another occasion in case 23, the patient submitted a sick call request with multiple complaints, including shortness of breath. The nurse triaged the sick call and scheduled the patient to be seen by a nurse within one business day. However, a nurse should have evaluated the patient the same day due to the complaint of shortness of breath.

- In case 50, the patient submitted a sick call request for symptoms of dry cough for two days as well as throat and chest pain. The nurse triaged the sick call but did not schedule the patient for a same day evaluation to address the patient's symptoms. Instead, the nurse scheduled the patient to be seen the next business day. However, the patient was not evaluated the next day because the patient tested positive for COVID-19, and the appointment was cancelled. Nevertheless, the patient should have been evaluated for the symptoms regardless of the patient testing positive for COVID-19.

- In case 53, the nurse evaluated the patient, who had symptoms of foot swelling, shortness of breath, an inability to breathe when laying down, and an elevated blood pressure. The nurse did not co-consult with a provider or reassess the patient's elevated blood pressure.

### Outpatient Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Outpatient clinic nurses mostly performed good documentation. However, we identified a pattern of nurse deficiencies with missing documentation of administering protocol medication on the medication administration record and not always providing patient education.[50] Nonetheless, these deficiencies did not affect overall patient care.

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[48] Deficiencies occurred in cases 2, 17, 19, 21–24, 36–38, 40, 42–48, 50, 52–55, 57, and 59–62. Significant deficiencies occurred in cases 19, 23, 24, 50, 52, 53, 57, and 59.

[49] Incomplete sick call assessments and reassessments occurred in cases 2, 17, 22, 23, 40, 44–48, 52–54, 59, and 62. Lack of interventions occurred in cases 19, 23, 24, 42, 43, 50, 52, 53, 54, 57, 59, and 61.

[50] During the sick call process, nurses did not document the administration of medications on the medication administration record in cases 37, 38, 45, 55, and 57. Nurses did not provide patient education during the sick call process in cases 17, 19, 37, 40, 45–47, 55, 60, and 62.

### Wound Care

We reviewed three cases involving wound care orders.[51] Two of the patients were housed in the CTC and one in hospice. Nurses generally performed wound care as ordered.

### Emergency Services

We reviewed 34 urgent or emergent events and found 27 emergency care deficiencies. Of these 27 deficiencies, seven were significant. First responders responded promptly to emergent events with generally good assessments and documentation. However, TTA nurses needed improvement in nursing assessments, interventions, and immediate activation of EMS. Please see the **Emergency Services** indicator for further details.

### Hospital Returns

We reviewed 26 events in which patients returned from off-site hospitals or emergency room visits and identified 15 deficiencies, four of which were significant. The nurses frequently performed good nursing assessments. Our clinicians did not identify any significant nursing performance deficiencies. For additional information, please refer to the **Transfers** indicator.

### Transfers

CMF's nursing performance for the transfer process was good. Our clinicians reviewed 12 events involving the transfer-in and transfer-out processes and identified three deficiencies, none of which were significant. When patients arrived at CMF, R&R nurses completed the initial health screening forms, scheduled required appointments, and completed medication reconciliation. For patients transferring out of CMF, R&R nurses verified the transfer packets were complete and patients had required DME and medications. For additional information, please refer to the **Transfers** indicator.

### Specialized Medical Housing

SMH nurses needed improvement in performing thorough daily patient assessments, reassessing patients with abnormal vital signs, and notifying the provider of abnormal findings. We reviewed 112 nursing events in 10 cases. For most of the cases reviewed, patients were housed in the CTC. Additional information is detailed in the **Specialized Medical Housing** indicator.

### Specialty Services

Specialty services nurses performed well. We reviewed 36 nursing events in which patients returned from off-site specialty procedures or consultations. Case review identified five deficiencies, none of which were significant.[52] Please refer to the **Specialty Services** indicator for additional information.

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[51] Nurses performed wound care in cases 1, 9, and 25.

[52] We reviewed nursing encounters in cases 1, 2, 11, 15, 17, 19, 22–25, 28, and 29. Deficiencies occurred in cases 2, 22, and 29.

### Medication Management

CMF's performance for medication management was satisfactory with opportunities for improvement in continuity of chronic medications and specialized medical housing medications. Our clinicians reviewed 155 events related to medication management and found 36 deficiencies, eight of which were significant. These are discussed further in the **Medication Management** indicator.

### Clinician On-Site Inspection

OIG clinicians toured the TTA, OHU, CTC, hospice, outpatient clinics, R&R, nursing education, and medication pill lines. We observed huddles, which were well organized. Patient care teams were familiar with their patient population and nurses were knowledgeable about processes in their perspective areas. Nurses reported good teamwork with staff in all areas we visited. The nurses reported a challenge of staff shortage with the consequence of redirection to different nursing areas. The nursing staff and supervisors stated their supervisors and leadership were approachable and receptive.

## *Recommendations*

- Nursing leadership should determine the challenges to nurses performing appropriate triage of sick calls, completing thorough face-to-face assessments, and co-consulting with the provider when needed and should implement remedial measures as appropriate.

## Provider Performance

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

### *Ratings and Results Overview*

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

CMF providers' performance was mixed in this indicator. Providers delivered good care for emergency services and hospice, while maintaining good provider continuity for patients. However, the providers needed improvement in patient assessment, decision making, review of records, management of diabetes, and follow up after specialty services. In carefully considering all aspects of this indicator, the OIG rated this indicator ***inadequate.***

### Case Review Results

OIG clinicians reviewed 226 medical provider encounters and identified 98 deficiencies, 40 of which were significant.[53] In addition, our clinicians examined the quality of care in 25 comprehensive cases. Of the 25 cases, we found 16 ***adequate*** and nine ***inadequate***.

#### Assessment and Decision Making

OIG clinicians found providers intermittently performed appropriate assessment and decision-making. We also identified a pattern of providers not completing proper examinations based on patient symptoms.[54] Examples include the following:

- In case 1, the patient presented with a sudden change in mental status. The provider evaluated the patient but did not perform an immediate work up. Instead, the provider ordered laboratory tests to be completed later that day. Once the laboratory test results were available and indicated a severe systemic infection, another provider did not order a close provider follow-up appointment or transfer the patient to the hospital for additional treatment.

[53] Deficiencies occurred in cases 1–3, 7, 8, 11, 13–25, 27–29, and 60. Significant deficiencies occurred cases 1, 3, 8, 11, 14, 16, 17, 19, 21, 23, 25, 27, and 28.

[54] Missing physical examination documentation occurred in cases 1, 2, 8, 11, 13, 15, 17–19, 21–23, and 28.

- In case 17, the provider evaluated the patient, who complained of chest pain and shortness of breath. However, the provider did not perform a thorough review of the patient's symptoms, document a physical examination, or consider ordering an electrocardiogram. This placed the patient at risk for undiagnosed heart disease.

- In case 19, the provider obtained a Holter monitor to evaluate a patient for a fast heart rhythm. The study showed an abnormal heart rhythm. However, the provider did not follow up on these abnormal results, which required further laboratory analysis, possible medication intervention, or consultation with a heart specialist.

- In case 27, the provider evaluated the patient for headaches and considered a diagnosis of temporal arteritis.[55] The provider started the patient on a steroid medication but did not order an urgent biopsy to confirm the diagnosis. When the provider eventually ordered the biopsy, the provider did not continue steroid treatment, which placed the patient at risk had the diagnosis been confirmed.

### Review of Records

Providers needed improvement in their review of medical records. We identified seven deficiencies related to poor medical records review, four of which were significant.[56] Examples are described below:

- In case 1, the provider evaluated the patient at a follow-up appointment after a hospitalization. During the hospitalization, the patient had an ultrasound test showing severe narrowing of the right carotid artery.[57] The provider's assessment documentation referred to an older ultrasound test, which had a different result. Consequently, the provider did not consider a carotid artery procedure to significantly reduce the patient's risk for having a stroke.

- In case 11, the provider evaluated the patient and documented anemia due to chronic disease.[58] However, the laboratory results showed the patient had iron deficiency anemia. Although the provider ordered iron supplementation, the provider did not change the diagnosis to iron deficiency anemia or address the patient's noncompliance with medication.

- In case 19, the provider evaluated the patient but did not review that the patient had presented recently to the TTA for a headache.

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[55] Temporal arteritis is a condition in which the arteries around the scalp are inflamed. An urgent biopsy is required to confirm the diagnosis and treatment includes steroids to reduce the risk of blindness.

[56] Review deficiencies occurred in cases 1, 8, 11, 16, 19, 23, and 27.

[57] Carotid artery stenosis is a narrowing of the artery supplying blood to the brain. An endarterectomy is a procedure to remove atherosclerotic plaque to reduce the risk for stroke.

[58] Anemia of chronic disease is a reduced red cell count secondary to a chronic inflammatory disease. The treatment for anemia of chronic disease is to address the underlying medical condition.

### Emergency Care

Providers generally made appropriate assessments and decisions for patients in the TTA who needed emergency treatment. Although providers were available for consultation with TTA nursing staff, we identified eight deficiencies related to incomplete provider progress notes.[59] However, these deficiencies did not significantly affect patient care.

### Chronic Care

Providers had variable performance in managing patients' chronic health conditions. While anticoagulation care and hospice care were satisfactory, we found room for improvement in diabetes and hypertension management. The following are examples:

- In case 8, the patient was on insulin for diabetes. On several occasions, the provider did not thoroughly review the patient's fingerstick sugar readings or diabetic laboratory tests. Instead, the provider significantly increased the patient's long-acting insulin, which placed the patient at risk for hypoglycemia.

- In case 16, the provider evaluated the patient for follow-up of uncontrolled diabetes and made medication changes. The provider should have followed the patient closely to assess the response to medication changes. Instead, the provider ordered a follow-up appointment to occur within 180 days.

- In case 25, the provider evaluated the patient for hypertension and documented blood pressure was at its goal on hydrochlorothiazide.[60] However, the patient's blood pressure was elevated, and the patient did not have an active order for hydrochlorothiazide.

### Specialty Services

Providers generally referred patients to specialists when medically indicated. However, providers often did not order appropriate follow-ups based on the clinical condition or follow through on specialists' recommendations. We discuss providers' specialty performance further in the **Specialty Services** indicator.

- In case 3, during a hospitalization, the patient was found to have a large amount of fluid around his heart, for which the hospital providers recommended a procedure to remove the fluid. The CMF provider evaluated the patient at a follow-up appointment and ordered a routine (to occur within 90 days) referral to a cardiothoracic specialist when this should have been ordered urgently. Unfortunately, the patient was hospitalized less than two weeks later for cardiogenic shock secondary to excessive pericardial fluid and underwent emergency drain placement. This hospitalization could potentially have been prevented had the provider ordered the specialist referral sooner.

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[59] Emergency documentation deficiencies occurred in cases 7, 15 (twice), 19, 22, 23 (twice), and 24. None were significant.

[60] Hydrochlorothiazide is a diuretic blood pressure medication.

- Also in case 3, fluid around the patient's lung showed B-cell lymphoma.[61] The provider ordered a medium-priority (to occur within 45 days) referral to oncology instead of an urgent referral for a new cancer diagnosis.

- In case 14, the provider followed up with the patient after he had seen the kidney specialist, who recommended starting a medication to reduce the amount of protein in the urine. However, the provider did not order the medication as recommended by the specialist and did not provide an adequate medical justification.

- In case 23, the blood specialist evaluated the patient for follow-up of idiopathic thrombocytopenic purpura (ITP) and recommended an intravenous medication if the blood platelet count was low.[62] However, the provider did not order this medication when the platelet count was very low. Subsequently, the patient was sent to the hospital for this low blood platelet count and to receive the medication. This hospitalization could have been prevented had the provider ordered medication as recommended by the specialist.

### Documentation Quality

Providers documented accurately most of the time. We found minor deficiencies in which the providers did not document complete progress notes to include an assessment and diagnosis. The CTC providers sometimes cloned portions of their notes, which resulted in outdated information being carried over on subsequent encounters. Fortunately, these did not significantly impact patient care.

### Provider Continuity

CMF delivered good provider continuity. Providers were assigned to specific units, including the outpatient clinic and specialized medical housing. Providers covered for other units depending on staffing needs.

### Clinician On-Site Inspection

At the time of the on-site inspection, we spoke to medical leadership and providers. CMF had eight on-site providers and three telemedicine providers. Medical leadership reported a 30 percent vacancy rate among providers but a 15 to 26 percent vacancy rate during the period of review. The institution lost several seasoned providers, who either separated from State service or transferred to other institutions and headquarters.

Medical leadership reported provider morale had improved in part with after-hours coverage provided by the medical officer of the day (MOD), which reduced the on-call volume. We discussed with the chief medical executive (CME) and chief physician and surgeon (CP&S) the deficiencies attributed to providers, who no longer worked at the institution. Medical leadership explained they expected providers to document a physical examination depending on the patient's symptoms. They also expressed an expectation

[61] B-cell lymphoma is a cancer of the white blood cells.

[62] ITP is a medical condition with a significantly reduced platelet count. This condition may require immunosuppressive therapy to reduce the risk for life-threatening bleeding.

for providers to document meaningful co-consultations with nursing staff. Medical leadership reported difficulties recruiting providers despite the institution's location and 15 percent pay differential.

We discussed patient care with the providers. The providers stated their workload had increased significantly due to staffing shortages, and this created challenges in delivering care to the complex patient population. Some of the providers expressed their morale during the period of review was low mainly due to lack of providers and a heavy call burden. They reported a good relationship with custody staff to ensure patients were seen. The providers stated medical leadership was supportive of their efforts to take care of patients and alleviated the workload by seeing patients in the clinic.

## *Recommendations*

- The department should analyze the challenges to the recruitment and retention of providers at CMF and should implement remedial measures as appropriate.

- Medical leadership should analyze the challenges to providers documenting physical exams based on the patients' clinical presentations during an appointment and should implement remedial measures as appropriate.

- Medical leadership should determine the root cause(s) for providers not thoroughly addressing chronic conditions such as diabetes and should implement remedial measures as appropriate.

## Specialized Medical Housing

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

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Inadequate*** | ***Inadequate* (65.0%)** |

Case review found CMF needed improvement in this indicator. We found CTC nurses did not always perform thorough daily patient assessments and reassessments, notify the provider of abnormal findings, or activate 9-1-1 timely. Providers had problems with appropriate decision making, reviewing medical records thoroughly, and cloning notes. In addition, we found opportunities for improvement in medication management. Factoring in all the information, the OIG rated the case review component of this indicator ***inadequate***.

In compliance testing, CMF had a mixed performance in this indicator. Nurses performed excellently in timely completing admission assessments, and providers timely completed history and physicals (H&Ps). The inpatient housing units had a functional call light system. However, the nursing staff did not complete safety rounding checks thoroughly in the OHU. Lastly, staff performed poorly in administering medications for newly admitted patients within the required time frame. Considering the testing results, the OIG rated the compliance testing component of this indicator ***inadequate***.

### Case Review and Compliance Testing Results

We reviewed 362 events that included 148 provider events and 112 nursing events.[63] Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified 88 deficiencies, 34 of which were significant.[64]

[63] We reviewed events in cases 1–3, 8, 9–12, 22, 24, 25, and 27.

[64] Deficiencies occurred in cases 1–3, 8, 10, 11, 22, 24, 25, and 27. Significant deficiencies occurred in cases 1–3, 8, 11, 25, and 27.

### Provider Performance

Providers had mixed performance in their delivery of care in specialized medical housing. Compliance testing showed providers completed all admission H&Ps without delay (MIT 13.002, 100%). However, our clinicians found providers struggled with making appropriate decisions, reviewing medical records thoroughly, and cloning notes. We identified 46 deficiencies, 24 of which were significant.[65] The below are examples of the deficiencies:

- In case 1, medical staff informed the provider that the patient was experiencing arm pain radiating to the chin. The patient had known heart disease and a prior hospitalization for a heart attack. The patient's electrocardiogram changes resolved after the patient took nitroglycerin, and the provider considered the diagnosis of an underlying heart attack. However, the provider ordered for the patient to be transferred to the emergency room via State vehicle rather than by ambulance. In addition, the provider did not administer a full dose aspirin or supplemental oxygen.

- In case 3, the provider evaluated the patient during CTC rounding and ordered two diuretic blood pressure medications, which increased the patient's risk for kidney side effects.

- In case 11, the provider evaluated the patient, who had a history of anemia and gastrointestinal (GI) bleed, as needing to continue oral iron supplementation. However, the provider did not carefully review the MAR, which showed the patient's noncompliance with the iron. In addition, the provider considered further anemia work up but did not review the patient's refusal for the colon cancer testing.

- In case 25, the provider performed an admission H&P but cloned plans from the previous provider, such as "continue low dose hydrochlorothiazide and repeat BMP again through PICC." However, the patient had not been on the hydrochlorothiazide for over a month and the PICC was discontinued a month prior.[66]

We discuss these deficiencies further in the **Provider Performance** indicator.

### Nursing Performance

SMH nurses needed improvement with patient assessments and performing timely interventions. We reviewed 112 nursing events and identified 26 nursing deficiencies, four of which were significant. Most of the cases our clinicians reviewed were for patients housed in the CTC. Compliance testing showed nurses completed admission nursing assessments timely (MIT 13.001, 100%). OIG clinicians found SMH nurses timely

[65] Deficiencies occurred in cases 1–3, 8, 11, 24, 25, and 27. Significant deficiencies occurred in cases 1, 3, 8, 11, 25, and 27.

[66] A peripherally inserted central catheter (PICC) provides intravenous access to give administer fluids and medication.

performed admission assessments. However, the admission assessments were not always thorough.[67]

We identified patterns of missing assessment components and lack of reassessments.[68] The following are examples.

- In case 2, during October 2022, the LVNs administered the patient's three blood pressure medications despite the patient having low blood pressure readings. In addition, the LVNs did not inquire if the patient was symptomatic and did not notify the provider or RN of the abnormal low blood pressures.

- In case 3, the CTC nurse assessed the patient who had shallow breathing with an abnormally fast breathing rate. However, the nurse did not reassess the patient's vital signs until 42 minutes later.

During emergency situations, CTC nurses performed good assessments, but they did not always activate EMS immediately as illustrated in the following cases.

- In case 1, the CTC nurse assessed the patient, who had right sided weakness, but called EMS 13 minutes later.

- In case 25, the CTC LVN found the patient, who presented with left-sided facial drooping, left arm weakness, and decreased verbal response. The patient was transported to the TTA then transferred to a higher level of care. Instead of contacting EMS immediately, health care staff contacted EMS one hour after staff identified the initial symptoms. In addition, documentation in electronic health record indicated a 30-minute delay in provider notification for a patient with stroke-like symptoms.

The case review clinicians found CTC nurses needed improvement in notifying the provider with patient changes in vital signs, wound assessments, and change in condition.[69]

- In case 2, during the months of November and December in 2022, the patient, who required lactulose medication for hepatic encephalopathy, continued to have watery stools.[70] The patient had five to 20 episodes of watery stools in a day. The nurses held the lactulose per the provider orders; however, the nurses did not inform the provider of the continued frequency of the watery stools. The patient was at risk for electrolyte imbalance, dehydration, and falls.

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[67] Cases 3 and 10 were missing assessment components, such as heart, lung, and bowel sounds.

[68] Assessment deficiencies occurred in cases 1-3, 8, 10, 24, and 25. Patient reassessments did not occur in cases 3, 10, 24, and 25.

[69] Nurses did not notify or co-consult with the provider in cases 1, 2, 24, and 25. There were multiple deficiencies in case 25.

[70] Hepatic encephalopathy is a brain disorder caused by impaired liver function. Lactulose can cause loose stools.

We identified documentation deficiencies in a few cases.[71] However, they did not affect overall patient care.

### Medication Administration

Staff performed poorly in medication administration. Our case review clinicians identified 11 deficiencies related to medication management, two of which were significant.[72] The following are significant deficiencies.

- In case 3, during the month of March 2023, the CTC patient did not receive his antibiotic and blood pressure medications as ordered.[73]

- In case 25, from the months of October to November 2022, the patient did not receive nurse-administered chronic medications, such as blood pressure, blood thinner, cholesterol, and asthma medications on several days.

Compliance testing showed staff performed poorly in administering medications for newly admitted patients within the required time frame (MIT 13.003, 25.0%). Compliance testing sampled four patients for this MIT, showing medications were provided up to four doses late. In addition, aspirin, an essential medication, was given one day late.

### Clinician On-Site Inspection

OIG clinicians toured the CTC, OHU, and the hospice unit. We attended well-organized huddles in the CTC and OHU. All required staff were present, and staff participation was good.

The CTC had 28 medical beds with one negative pressure room. During our inspection, the patient census was 27. CTC nursing staff consisted of three RNs and one LVN on first watch. Four RNs and three LVNs covered second and third watch. The shift lead takes care of patients and rounds with the provider Monday through Friday. The RNs perform head-to-toe assessments each shift. One LVN is the designated medication nurse on each watch. The other two LVNs on second and third watch assist with patient care.

The CTC has two designated providers and an on-call provider for after hours. The CTC nursing staff reported good teamwork in the unit, access to their SRN, and fair rapport with custody. They mentioned no issues with supplies, equipment, or pharmacy. During our inspection, the CTC shower call light was not functioning, and repair was in progress.

We also interviewed the CTC SRN, who explained they have staff meetings monthly and as needed. Recent meeting topics included real time documentation, improving documentation by focusing on patient diagnosis, fall prevention, and improving follow-

[71] Documentation deficiencies occurred in cases 2, 3, 11, 24, and 25. Significant deficiencies occurred in case 3 and 25.

[72] Medication management deficiencies occurred in cases 1–3, 22, 24, and 25.

[73] Vancomycin is an antibiotic medication. Bumex is a diuretic medication used to reduce blood pressure and treat congestive heart failure.

up on medication effectiveness. The supervisor reported the CNE is supportive, receptive, and personable.

The OHU had 47 medical beds and one negative pressure room. The staff reported the average census was 47. They had one provider designated to the OHU who was available Monday, Tuesday, Wednesday, and Friday, from 7:00 a.m. until 5:00 p.m. The providers recently started 10-hour shifts. An on-call provider is available Thursdays and after hours. Nursing staff consists of two LVNs on first and third watch. Two RNs and one medical assistant (MA) cover second watch. One of the RNs on second watch administers medications. Some of the duties of the second RN include patient rounds, triage of sick calls, admissions, discharges, and wound care. The MA orders weekly supplies, performs vital signs, and assists with the provider line. We were informed 70 percent of the patients in OHU were elderly, had fall risks, and were on multiple medications. The OHU staff reported they had issues with receiving medications timely from pharmacy and needed more support staff.

Lastly, we toured the hospice unit which had 16 of its 17 beds occupied. The average census in hospice is 10 patients. The hospice unit has an assigned provider with an on-call provider for after hours. This unit's staffing had three RNs on first watch and third watch. Four RNs covered second watch. They reported receiving medications without delay from pharmacy. Staff stated one of their challenges was the redirection of staff to other assignments.

The hospice unit had a garden area available for patient use. The unit also had two social workers who assisted with facilitating communication with patient families. Twenty-four-hour pastoral care is offered to hospice patients who are nearing the end of life.

## Compliance Testing Results

### Compliance On-Site Inspection and Discussion

At the time of the compliance on-site inspection, five inpatient housing units maintained an operational call light system (MIT 13.101, 100%). The OHU call light system was in disrepair and was not clearly labeled or identified at the time of the inspection; however, this factor was not scored because OHU call light system testing is exempted in MIT 13.101.[74] In addition, staff in the OHU had several missing entries in the patients' safety check log for the most recent three days as required in the institution's local operating procedure in an event the call light system is inoperable (MIT 13.102, zero).

[74] Unlike the inpatient units that are governed by Title 22, the OHU is not required to have a call light communicating system.

## Compliance Testing Results

### Table 16. Specialized Medical Housing

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001) | 4 | 0 | 0 | 100% |
| Was a written history and physical examination completed within the required time frame? (13.002) | 4 | 0 | 0 | 100% |
| Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003) | 1 | 3 | 0 | 25.0% |
| For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101) | 5 | 0 | 1 | 100% |
| For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) | 0 | 1 | 5 | 0 |
| | | | | Overall percentage (MIT 13): **65.0%** |

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

## *Recommendations*

- Nursing leadership should analyze the challenges in SMH nurses not performing complete assessments, recognizing changes in patient status, or intervening timely and appropriately and should implement remedial measures as appropriate.

- Leadership should analyze the root cause(s) for CTC staff not activating the 9-1-1 system immediately for emergent patients requiring a higher level of care and should implement remedial measures as appropriate.

- Medical leadership should analyze the root cause(s) for providers not completing accurate documentation and not making appropriate decisions and should implement remedial measures as appropriate.

## Specialty Services

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

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Inadequate*** | ***Inadequate* (53.5%)** |

Case review found CMF had variable performance with specialty services. Providers generally ordered appropriate specialty consultations, while nurses performed sufficiently in assessing patients who returned from off-site specialty appointments. However, we identified some deficiencies in specialty access, provider performance, and nursing assessments. Moreover, we found significant deficiency patterns in the management of specialty reports. Factoring in all the information, the OIG rated the case review component of this indicator ***inadequate***.

CMF performed poorly in compliance testing for this indicator. Compliance testing resulted in low scores for providing preapproved specialty services; high-, medium-, and routine-priority services; and subsequent follow-up appointments. In addition, CMF showed poor performance in retrieving and endorsing specialty reports. Factoring in the test results, the OIG rated the compliance testing component of this indicator ***inadequate***.

### Case Review and Compliance Testing Results

The OIG clinicians reviewed 165 events related to specialty services, which included 128 specialty consultations and procedures and 36 nursing encounters. We identified 55 deficiencies in this category, 15 of which were significant.[75]

#### Access to Specialty Services

Compliance testing showed the institution needed improvement in providing high-, medium-, and routine-priority specialty appointments within required time frames (MIT 14.001, 66.7%; MIT 14.004, 53.3%; MIT 14.007, 66.7%). Case review identified two significant deficiencies as follows:

[75] Deficiencies occurred in cases 1–3, 11, 12, 14, 15, 17, 22, 23, 25, and 26–29. Significant deficiencies occurred in cases 3, 14, 15, 17, 22, 23, 25, and 28.

- In case 3, the provider ordered an urgent PET /CT imaging scan for the patient, who was newly diagnosed with B-cell lymphoma and pancreatic lesions.[76] However, the scan was not completed timely.

- In case 25, the provider requested a follow-up colonoscopy with medium-priority level to follow the patient's history of colon cancer. However, this procedure did not occur.

### Provider Performance

Compliance testing showed CMF did not always provide timely clinician follow-up appointments after specialty consultations (MIT 1.008, 66.7%). However, providers generally ordered appropriate specialty consultations and followed specialty recommendations. We found two deficiencies related to the provider not implementing specialty recommendations, only one of which was significant.[77]

Further discussion can be found in the **Provider Performance** indicator.

### Nursing Performance

CMF nurses performed satisfactorily in assessing patients who returned to the institution from off-site specialty appointments. We identified four deficiencies in which the TTA nurse did not properly assess a patient returning from a specialty appointment or ensure specialty recommendations were made available.[78] However, none of these deficiencies were significant.

### Health Information Management

Compliance testing showed CMF staff struggled significantly with timely retrieval and review of specialty reports for routine-priority (MIT 14.008, 21.4%), medium-priority (MIT 14.005, 20.0%), and high-priority (MIT 14.002, 26.7%) services. Similarly, CMF staff only sometimes timely scanned specialty reports into the electronic health record (MIT 4.002, 53.3%). Case review found deficiency patterns in specialty health information management. We identified 43 health information management deficiencies of different types: 27 delayed or mislabeled scans, 15 late provider endorsements, and one report that was not properly forwarded to the provider for review.[79]

Further discussion can be found under the **Health Information Management** indicator.

### Clinician On-Site Inspection

We met with the specialty services SRN to discuss specialty services care. At the time of the on-site inspection, the SRN reported a backlog of five specialty appointments (cardiothoracic and lumbar spine surgery) and other factors in the untimely completion of

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[76] A positron emission tomography (PET) scan is an imaging test of organs and soft tissues. A CT scan is a computed, or computerized, tomography imaging scan.

[77] Deficiencies occurred in cases 1 and 3. A significant deficiency occurred in case 3.

[78] Deficiencies occurred in cases 22 and 29. None of these deficiencies were significant.

[79] Deficiencies occurred in cases 1, 11, 12, 14, 15, 17, 22, 23, and 25–29. Significant deficiencies occurred in cases 14, 15, 17, 22, 23, and 28.

specialty services. In addition to specialty unavailability, the SRN identified bad weather, refusal of service by the specialist when the patient was late due to traffic, and patient refusals as added barriers to timely completion of specialty services.

The SRN reported significant off-site, specialty access challenges. For example, she explained difficulties to obtain urologic services due to the limited number of available appointments. She shared CMF alone requested 27 urology appointments monthly, but the urology specialist only provided 40 appointments per month. This appointment pool was available to other institutions and was booked on a first come first serve basis. The SRN explained processing referral requests was time consuming. If the specialty staff was unable to book an appointment with three different specialists for a particular service, they would then request headquarters approval for specialists beyond the service area. The process required even more time consuming when searching for tertiary care specialty services. In addition to arranging off-site specialty services, the specialty nurse also scheduled off-site radiology procedures.

The specialty services SRN reported audiology, optometry, and podiatry on-site services were currently available. Audiology provided hearing aid services and an ocularist provided care for prosthetic eyes. The ophthalmologist had recently retired, and a gastroenterologist provided on-site services. One of the CP&S providers trained the other providers for podiatric procedures and an RN performed routine foot care.

We discussed health information management processes with the health records supervisor for the psychiatric inpatient program (PIP), health records supervisor for medical, and the correctional health services administrator (CHSA). The health records supervisors described the process of retrieving documents from off-site specialty reports and routing them to the providers for review. Health information management staff reviewed the "Daily Movement Sheet" (DMS) every day to check which patients had off-site specialty appointments. The staff then compiled this information into a spreadsheet one day following the appointment and would fax the records requests to the performing specialist or associated health care vendor.

## Compliance Testing Results

### Table 17. Specialized 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) | 10 | 5 | 0 | 66.7% |
| 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) | 4 | 11 | 0 | 26.7% |
| Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) | 8 | 2 | 5 | 80.0% |
| Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) | 8 | 7 | 0 | 53.3% |
| Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) | 3 | 12 | 0 | 20.0% |
| Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) | 5 | 4 | 6 | 55.6% |
| 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) | 10 | 5 | 0 | 66.7% |
| Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) | 3 | 11 | 1 | 21.4% |
| Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) | 4 | 2 | 9 | 66.7% |
| 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) | 6 | 14 | 0 | 30.0% |
| Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011) | 16 | 4 | 0 | 80.0% |
| Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012) | 15 | 5 | 0 | 75.0% |
| | | | Overall percentage (MIT 14): **53.5%** | |

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

## Table 18. Other Tests Related to Specialized Services

| | Scored Answer | | | |
|---|---|---|---|---|
| **Compliance Questions** | **Yes** | **No** | **N/A** | **Yes %** |
| Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) * | 28 | 14 | 3 | 66.7% |
| Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) | 16 | 14 | 15 | 53.3% |

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

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

## *Recommendations*

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

- Medical leadership should determine the root cause(s) of challenges to the timely retrieval, scanning, and endorsement of specialty reports and should implement remedial measures as appropriate.

## Administrative Operations

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

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

### *Ratings and Results Overview*

| Case Review Rating | Compliance Rating and Score |
|---|---|
| ***Not Applicable*** | ***Inadequate* (66.2%)** |

CMF's performance was mixed in this indicator. While CMF scored well in some applicable tests, it needed improvement in several areas. The Emergency Medical Response Review Committee (EMRRC) did not review some cases timely and did not always complete the required checklists.[80] In addition, in only one of the three samples, staff conducted a live medical emergency response drill with both nursing and custody staff. Physician managers sporadically completed probationary or annual appraisals in a timely manner. The nurse educator did not ensure nurses who administer medication complete their annual competency testing in a timely manner and newly hired nurses receive the required onboarding training. These findings are set forth in the table on the next page. Overall, the OIG rated this indicator ***inadequate***.

### Compliance Testing Results

#### Nonscored Results

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

We obtained CCHCS Mortality Case Review reporting data. In our inspection, for six patients, we found no evidence in the submitted documentation that the preliminary mortality reports had been completed. These reports were overdue at the time of OIG's

[80] CMF did not submit the required checklist for one sample in our preinspection documents.

inspection. The compliance due dates for the remaining four reports fell outside the inspection review period and, as such, were deemed exempted (MIT 15.998).

## Compliance Testing Results

### Table 19. Administrative Operations

| Compliance Questions | Scored Answer | | | |
|---|---|---|---|---|
| | Yes | No | N/A | Yes % |
| For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) | This is a nonscored test. Please refer to the discussion in this indicator. | | | |
| Did the institution's Quality Management Committee (QMC) meet monthly? (15.002) | 6 | 0 | 0 | 100% |
| For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003) | 5 | 7 | 0 | 41.7% |
| 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) | 3 | 1 | 0 | 75.0% |
| Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101) | 1 | 2 | 0 | 33.3% |
| Did the responses to medical grievances address all of the patients' appealed issues? (15.102) | 10 | 0 | 0 | 100% |
| Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103) | 9 | 1 | 0 | 90.0% |
| Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104) | 0 | 10 | 0 | 0 |
| Did physician managers complete provider clinical performance appraisals timely? (15.105) | 4 | 15 | 1 | 21.1% |
| Did the providers maintain valid state medical licenses? (15.106) | 27 | 0 | 0 | 100% |
| Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107) | 2 | 0 | 1 | 100% |
| Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108) | 6 | 0 | 1 | 100% |
| Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109) | 2 | 0 | 0 | 100% |
| Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110) | 0 | 1 | 0 | 0 |
| Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998) | This is a nonscored test. Please refer to the discussion in this indicator. | | | |
| What was the institution's health care staffing at the time of the OIG medical inspection? (15.999) | This is a nonscored test. Please refer to Table 3 for CCHCS-provided staffing information. | | | |
| | | | | Overall percentage (MIT 15): **66.2%** |

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

## *Recommendations*

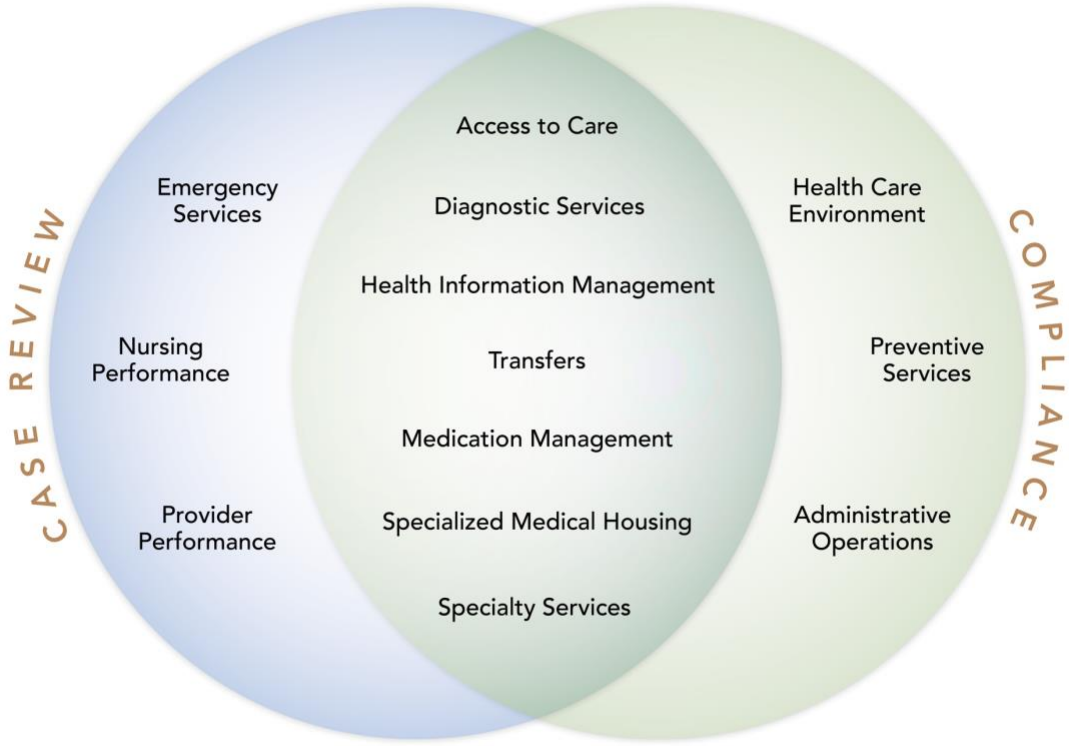
The OIG offers no recommendations for this indicator.

# 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 CMF**




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

## Case Reviews

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

**Table A–1. Case Review Definitions**

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

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

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

## *Case Review Sampling Methodology*

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

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

## *Case Review Testing Methodology*

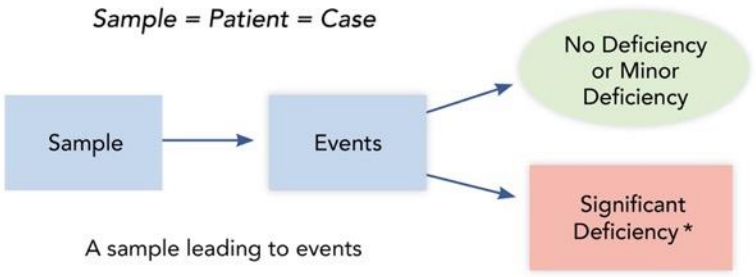
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

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

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

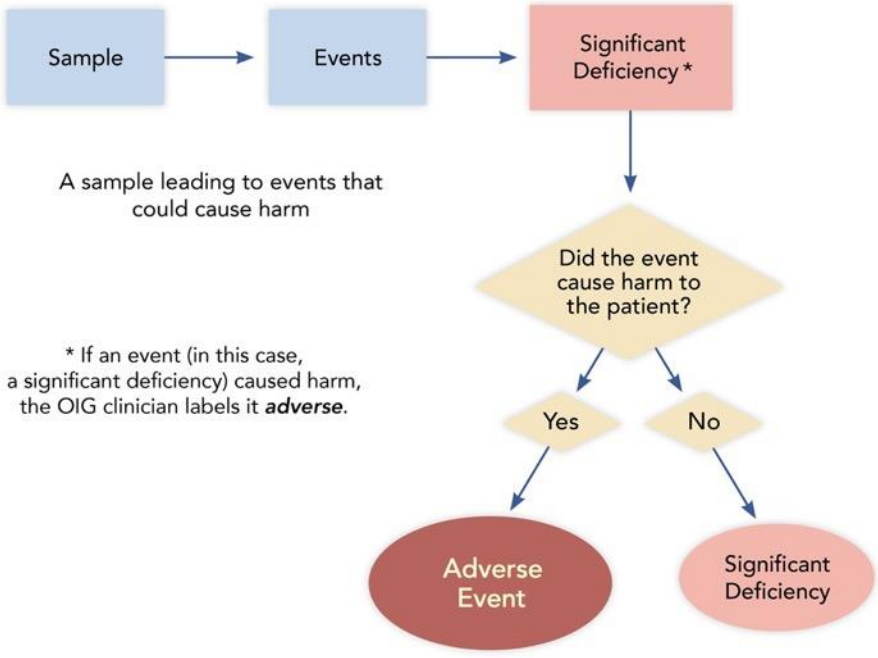
**Figure A–2. Case Review Testing**

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




***Deficiencies***

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



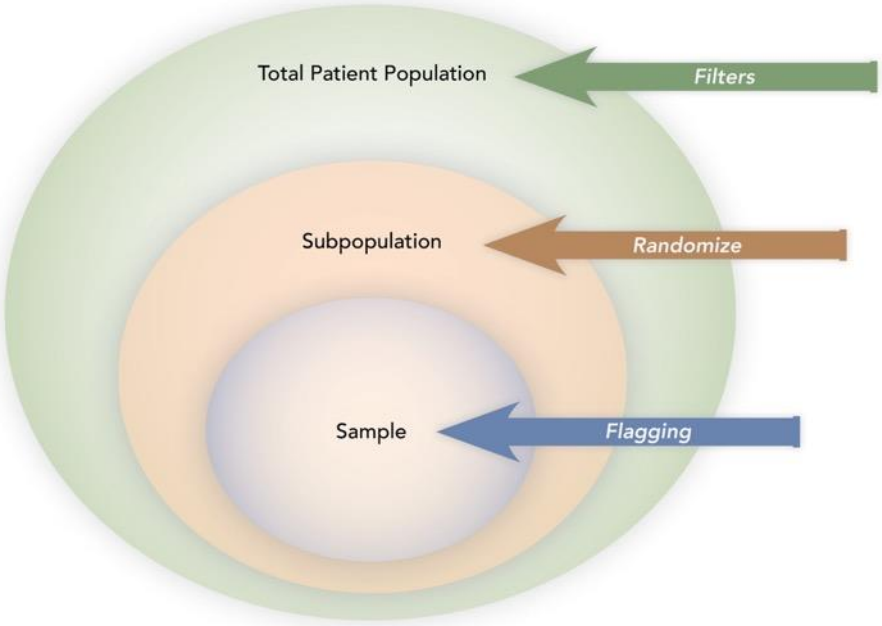

Source: The Office of the Inspector General medical inspection analysis.

# Compliance Testing

## *Compliance Sampling Methodology*

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

**Figure A–3. Compliance Sampling Methodology**




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

## *Compliance Testing Methodology*

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

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

## *Scoring Methodology*

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

## Indicator Ratings and the Overall Medical Quality Rating

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

# Appendix B: Case Review Data

## Table B–1. CMF Case Review Sample Sets

| Sample Set | Total |
|---|---|
| Anticoagulation | 3 |
| Death Review/Sentinel Events | 3 |
| Diabetes | 3 |
| Emergency Services – CPR | 4 |
| Emergency Services – Non-CPR | 3 |
| High Risk | 5 |
| Hospitalization | 4 |
| Intrasystem Transfers In | 3 |
| Intrasystem Transfers Out | 3 |
| RN Sick Call | 28 |
| Specialty Services | 4 |
| | **63** |

## Table B–2. CMF Case Review Chronic Care Diagnoses

| Sample Set | Total |
|---|---|
| Anemia | 16 |
| Anticoagulation | 5 |
| Arthritis/Degenerative Joint Disease | 9 |
| Asthma | 8 |
| COPD | 6 |
| COVID-19 | 2 |
| Cancer | 9 |
| Cardiovascular Disease | 8 |
| Chronic Kidney Disease | 7 |
| Chronic Pain | 22 |
| Cirrhosis/End-Stage Liver Disease | 10 |
| Coccidioidomycosis | 3 |
| Deep Venous Thrombosis/Pulmonary Embolism | 3 |
| Diabetes | 17 |
| Gastroesophageal Reflux Disease | 16 |
| Gastrointestinal Bleed | 1 |
| Hepatitis C | 13 |
| HIV | 4 |
| Hyperlipidemia | 29 |
| Hypertension | 37 |
| Mental Health | 23 |
| Migraine Headaches | 2 |
| Rheumatological Disease | 1 |
| Seizure Disorder | 2 |
| Sleep Apnea | 9 |
| Substance Abuse | 14 |
| Thyroid Disease | 7 |
| | **283** |

## Table B–3. CMF Case Review Events by Program

| Diagnosis | Total |
|---|---|
| Diagnostic Services | 359 |
| Emergency Care | 55 |
| Hospitalization | 40 |
| Intrasystem Transfers In | 6 |
| Intrasystem Transfers Out | 6 |
| Outpatient Care | 331 |
| Specialized Medical Housing | 362 |
| Specialty Services | 179 |
| | **1,338** |

## Table B–4. CMF Case Review Sample Summary

| Sample Set | Total |
|---|---|
| MD Reviews Detailed | 25 |
| MD Reviews Focused | 1 |
| RN Reviews Detailed | 14 |
| RN Reviews Focused | 41 |
| Total Reviews | 81 |
| Total Unique Cases | 63 |
| Overlapping Reviews (MD & RN) | 18 |

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# Appendix C: Compliance Sampling Methodology

## *California Medical Facility*

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Access to Care* | | | | |
| MIT 1.001 | Chronic Care Patients | 25 | Master Registry | • Chronic care conditions (at least one condition per patient—any risk level)<br>• Randomize |
| MIT 1.002 | Nursing Referrals | 25 | OIG Q: 6.001 | • See Transfers |
| MITs 1.003–006 | Nursing Sick Call (6 per clinic) | 40 | Clinic Appointment List | • Clinic (each clinic tested)<br>• Appointment date (2–9 months)<br>• Randomize |
| MIT 1.007 | Returns From Community Hospital | 14 | 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)<br>• Randomize<br>• Abnormal |
| MITs 2.004–006 | Laboratory | 10 | Quest | • Appt. date (90 days–9 months)<br>• Order name (CBC or CMPs only)<br>• Randomize<br>• Abnormal |
| MITs 2.007–009 | Laboratory STAT | 10 | Quest | • Appt. date (90 days–9 months)<br>• Order name (CBC or CMPs only)<br>• Randomize<br>• Abnormal |
| MITs 2.010–012 | Pathology | 10 | InterQual | • Appt. date (90 days–9 months)<br>• Service (pathology related)<br>• Randomize |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Health Information Management (Medical Records)* | | | | |
| MIT 4.001 | Health Care Services Request Forms | 40 | OIG Qs: 1.004 | • Nondictated documents<br>• First 20 IPs for MIT 1.004 |
| MIT 4.002 | Specialty Documents | 45 | OIG Qs: 14.002, 14.005 & 14.008 | • Specialty documents<br>• First 10 IPs for each question |
| MIT 4.003 | Hospital Discharge Documents | 14 | OIG Q: 4.005 | • Community hospital discharge documents<br>• First 20 IPs selected |
| MIT 4.004 | Scanning Accuracy | 24 | Documents for any tested incarcerated person | • Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No) |
| MIT 4.005 | Returns From Community Hospital | 14 | CADDIS off-site admissions | • Date (2–8 months)<br>• Most recent 6 months provided (within date range)<br>• Rx count<br>• Discharge date<br>• Randomize |
| *Health Care Environment* | | | | |
| MITs 5.101–105<br>MITs 5.107–111 | Clinical Areas | 18 | 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)<br>• Arrived from (another departmental facility)<br>• Rx count<br>• Randomize |
| MIT 6.101 | Transfers Out | 0 | 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<br>• At least one condition per patient—any risk level<br>• Randomize |
| MIT 7.002 | New Medication Orders | 25 | Master Registry | • Rx count<br>• Randomize<br>• Ensure no duplication of IPs tested in MIT 7.001 |
| MIT 7.003 | Returns From Community Hospital | 14 | 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)<br>• To location/from location (yard to yard and to/from ASU)<br>• Remove any to/from MHCB<br>• NA/DOT meds (and risk level)<br>• Randomize |
| MIT 7.006 | En Route | 10 | SOMS | • Date of transfer (2–8 months)<br>• Sending institution (another departmental facility)<br>• Randomize<br>• 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 | 2 | OIG inspector on-site review | • Identify & inspect all on-site pharmacies |
| MIT 7.112 | Medication Error Reporting | 24 | Medication error reports | • All medication error reports with Level 4 or higher<br>• Select total of 25 medication error reports (recent 12 months) |
| MIT 7.999 | Restricted Unit KOP Medications | 0 | On-site active medication listing | • KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Prenatal and Postpartum Care* | | | | |
| MITs 8.001–007 | Recent Deliveries | N/A at this institution | OB Roster | • Delivery date (2–12 months)<br>• Most recent deliveries (within date range) |
| | Pregnant Arrivals | N/A at this institution | OB Roster | • Arrival date (2–12 months)<br>• Earliest arrivals (within date range) |
| *Preventive Services* | | | | |
| MITs 9.001–002 | TB Medications | 5 | Maxor | • Dispense date (past 9 months)<br>• Time period on TB meds (3 months or 12 weeks)<br>• Randomize |
| MIT 9.003 | TB Evaluation, Annual Screening | 25 | SOMS | • Arrival date (at least 1 year prior to inspection)<br>• Birth month<br>• Randomize |
| MIT 9.004 | Influenza Vaccinations | 25 | SOMS | • Arrival date (at least 1 year prior to inspection)<br>• Randomize<br>• 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)<br>• Date of birth (45 or older)<br>• Randomize |
| MIT 9.006 | Mammogram | N/A at this institution | SOMS | • Arrival date (at least 2 yrs. prior to inspection)<br>• Date of birth (age 52–74)<br>• Randomize |
| MIT 9.007 | Pap Smear | N/A at this institution | SOMS | • Arrival date (at least three yrs. prior to inspection)<br>• Date of birth (age 24–53)<br>• Randomize |
| MIT 9.008 | Chronic Care Vaccinations | 25 | OIG Q: 1.001 | • Chronic care conditions (at least 1 condition per IP—any risk level)<br>• Randomize<br>• Condition must require vaccination(s) |
| MIT 9.009 | Valley Fever | N/A at this institution | Cocci transfer status report | • Reports from past 2–8 months<br>• Institution<br>• Ineligibility date (60 days prior to inspection date)<br>• All |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Reception Center* | | | | |
| MITs 12.001–007 | RC | N/A at this institution | SOMS | • Arrival date (2–8 months)<br>• Arrived from (county jail, return from parole, etc.)<br>• Randomize |
| *Specialized Medical Housing* | | | | |
| MITs 13.001–003 | Specialized Health Care Housing Unit | 4 | CADDIS | • Admit date (2–8 months)<br>• Type of stay (no MH beds)<br>• Length of stay (minimum of 5 days)<br>• Rx count<br>• Randomize |
| MITs 13.101–102 | Call Buttons | All | OIG inspector on-site review | • Specialized Health Care Housing<br>• Review by location |
| *Specialty Services* | | | | |
| MITs 14.001–003 | High-Priority Initial and Follow-Up RFS | 15 | Specialty Services Appointments | • Approval date (3–9 months)<br>• Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services<br>• Randomize |
| MITs 14.004–006 | Medium-Priority Initial and Follow-Up RFS | 15 | Specialty Services Appointments | • Approval date (3–9 months)<br>• Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services<br>• Randomize |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Specialty Services (continued)* | | | | |
| MITs 14.007–009 | Routine-Priority Initial and Follow-Up RFS | 15# | Specialty Services Appointments | • Approval date (3–9 months)<br>• Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services<br>• Randomize |
| MIT 14.010 | Specialty Services Arrivals | 20 | Specialty Services Arrivals | • Arrived from (other departmental institution)<br>• Date of transfer (3–9 months)<br>• Randomize |
| MITs 14.011–012 | Denials | 20 | InterQual | • Review date (3–9 months)<br>• Randomize |
| | | N/A | IUMC/MAR Meeting Minutes | • Meeting date (9 months)<br>• Denial upheld<br>• Randomize |
| *Administrative Operations* | | | | |
| MIT 15.001 | Adverse/sentinel events | 0 | Adverse/sentinel events report | • Adverse/Sentinel events (2–8 months) |
| MIT 15.002 | QMC Meetings | 6 | Quality Management Committee meeting minutes | • Meeting minutes (12 months) |
| MIT 15.003 | EMRRC | 12 | EMRRC meeting minutes | • Monthly meeting minutes (6 months) |
| MIT 15.004 | LGB | 4 | LGB meeting minutes | • Quarterly meeting minutes (12 months) |
| MIT 15.101 | Medical Emergency Response Drills | 3 | On-site summary reports & documentation for ER drills | • Most recent full quarter<br>• 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 | 10 | Institution-list of deaths in prior 12 months | • Most recent 10 deaths<br>• Initial death reports |

| Quality Indicator | Sample Category | No. of Samples | Data Source | Filters |
|---|---|---|---|---|
| *Administrative Operations (continued)* | | | | |
| MIT 15.104 | Nursing Staff Validations | 10 | On-site nursing education files | • On duty one or more years<br>• Nurse administers medications<br>• Randomize |
| MIT 15.105 | Provider Annual Evaluation Packets | 20 | On-site provider evaluation files | • All required performance evaluation documents |
| MIT 15.106 | Provider Licenses | 27 | Current provider listing (at start of inspection) | • Review all |
| MIT 15.107 | Medical Emergency Response Certifications | All | On-site certification tracking logs | • All staff<br>• Providers (ACLS)<br>• Nursing (BLS/CPR)<br>• Custody (CPR/BLS) |
| MIT 15.108 | Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications | All | On-site tracking system, logs, or employee files | • All required licenses and certifications |
| MIT 15.109 | Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations | All | On-site listing of provider DEA registration #s & pharmacy registration document | • All DEA registrations |
| MIT 15.110 | Nursing Staff New Employee Orientations | All | Nursing staff training logs | • New employees (hired within last 12 months) |
| MIT 15.998 | CCHCS Mortality Case Review | 10 | OIG summary log: deaths | • Between 35 business days & 12 months prior<br>• California Correctional Health Care Services mortality reviews |

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# California Correctional Health Care Services' Response

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August 9, 2024

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

Dear Ms. Singh:

California Correctional Health Care Services has reviewed the draft Medical Inspection Report for California Medical Facility (CMF) conducted by the Office of the Inspector General (OIG) from October 22 to March 2023. Thank you for preparing the report.

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

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7F5B95AC0A4D1...

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

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
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Heather Pool, Chief Assistant Inspector General, OIG
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
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# Cycle 7

# Medical Inspection Report

*for*

# California Medical Facility

OFFICE *of the*
INSPECTOR GENERAL

*Amarik K. Singh*
Inspector General

*Neil Robertson*
Chief Deputy Inspector General

STATE *of* CALIFORNIA
August 2024

OIG