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Independent Prison Oversight

August 2024

Cycle 7

Medical Inspection Report

California State Prison Corcoran

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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.

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[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 State Prison, Corcoran (COR), the institution had been delegated back to the department by the receiver.

We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from September 2022 to February 2023.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between April 2022 and October 2022.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of COR in July 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between September 2022 and February 2023.

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

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

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 49 cases, which contained 887 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 July 2023 to verify their initial findings. OIG physicians rated the quality of care in 20 comprehensive case reviews. Of these 20 cases, our physicians rated 15 ***adequate*** and 5 ***inadequate***. Our physicians found two 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 424 patient records and 1,229 data points and used the data to answer 95 policy questions. In addition, we observed COR processes during an on-site inspection in May 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.[5]

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

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

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

		Ratings: Proficient / Adequate / Inadequate		Scoring Ranges: 100%–85.0% / 84.9%–75.0% / 74.9%–0		
		Case Review		Compliance		
MIT Number	Health Care Indicators	Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*
1	Access to Care	Adequate	=	68.9%	80.0%	↓
2	Diagnostic Services	Adequate	=	48.3%	49.6%	=
3	Emergency Services	Adequate	=	N/A	N/A	N/A
4	Health Information Management	Adequate	=	68.1%	89.9%	↓↓
5	Health Care Environment†	N/A	N/A	52.4%	45.8%	=
6	Transfers	Inadequate	=	72.3%	51.2%	=
7	Medication Management	Inadequate	=	41.7%	51.4%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	66.1%	59.8%	=
10	Nursing Performance	Inadequate	=	N/A	N/A	N/A
11	Provider Performance	Adequate	↑	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	Inadequate	↓	59.6%	85.0%	↓↓
14	Specialty Services	Adequate	=	70.8%	71.6%	=
15	Administrative Operations†	N/A	N/A	72.4%	71.9%	=

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

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

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

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[6]

The OIG found two adverse events at COR during the Cycle 7 inspection.

- In case 14, a provider ordered an increased dose of morning long-acting insulin, and the patient had already received his morning long-acting insulin. Subsequently, the patient received two morning doses of long-acting insulin, placing the patient at risk of hypoglycemia.[7] Fortunately, the patient refused his evening dose of long-acting insulin.

- In case 22, the patient was anemic with positive fecal occult test suggestive for gastrointestinal bleed, and the gastroenterologist recommended a repeat colonoscopy be performed due to poor bowel preparation on the first procedure. However, the provider did not address the recommendation, placing the patient at risk of undiagnosed colon cancer as the cause of occult gastrointestinal bleed.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to COR. Of these 10 indicators, OIG clinicians rated six ***adequate*** and four ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 15 were ***adequate*** and five were ***inadequate***. In the 887 events reviewed, there were 326 deficiencies, 81 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 COR:

- Staff performed well in health information management, especially in scanning patients' requests for medical care, and in timely retrieving hospital records, diagnostic tests, and pathology reports.

- Providers made appropriate assessments and decisions, managed chronic medical conditions effectively, and reviewed medical records thoroughly.

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

[7] Hypoglycemia is a medical condition in which the blood sugar level is lower than the normal standard range.

Our clinicians found the following weaknesses at COR:

- Outpatient nursing performance was poor with incomplete assessments and delays in evaluating symptomatic sick call patients.
- Specialized medical housing nurses also performed poorly with incomplete assessments, lack of appropriate interventions, and missed care plans.
- Providers did not always thoroughly address specialists' recommendations.
- Staff performed poorly in medication management with new medications, hospital discharge medications, and transfer medications.

Compliance Testing Results

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

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

- Medical staff performed adequately in scanning hospital discharge reports and requests for health care services into patients' electronic medical records within the required time frame.
- Patients returning from outside community hospitals saw their primary care providers within the specified time frames. Moreover, patients were timely referred to their providers upon arrival at the institution.
- The institution timely provided preventative services for their patients, such as influenza vaccination, annual testing for tuberculosis (TB), and colorectal cancer screenings.
- The institution completed medium-priority and routine-priority specialty services within required time frames.

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

- The institution did not consistently provide routine and STAT (immediate) laboratory services within the specified time frames.
- Providers did not often timely communicate results of diagnostic services. Most patient notification letters communicating test results were missing the date of the diagnostic service and whether the results were within normal limits.
- Patients did not always receive chronic care medications within the required time frames. We found poor medication continuity for patients returning from hospitalizations, patients admitted to specialized medical housing, patients transferring into and within COR, and patients laying over at COR.

- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters and during medication preparation and administration.
- Medical clinics had multiple expired medical supplies.
- Nursing staff did not regularly inspect emergency response bags.

Institution-Specific Metrics

California State Prison, Corcoran (COR), is located in the city of Corcoran in Kings County. As of April 2023, the institution housed more than 3,404 incarcerated persons. COR operates multiple clinics, including a specialty clinic, where staff members handle nonurgent requests for medical services; a receiving and release clinic (R&R), where staff conduct screenings; a triage and treatment area (TTA) for patients requiring urgent or emergency care; a correctional treatment center (CTC) to house patients requiring inpatient health services; and an outpatient housing unit (OHU) to treat patients who require assistance with activities of daily living, but who do not require a higher level of inpatient care. California Correctional Health Care Services (CCHCS) has designated COR as a basic care institution. Basic institutions are located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher risk patients. Basic institutions have the capability to provide limited specialty medical services and consultation for a patient population that is generally healthy. As of July 16, 2024, the department reports on its public tracker that 83 percent of COR's incarcerated population is fully vaccinated while 60 percent of COR's staff is fully vaccinated.[8]

In April 2023, the Health Care Services Master Registry showed COR had a total population of 3,404. A breakdown of the medical risk level of the COR population as determined by the department is set forth in Table 2 below.[9]

Table 2. COR Master Registry Data as of April 2023

High 2	378	11.1%
Medium	1,648	48.4%
Low	1,173	34.5%
Total	**3,404**	**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 4-27-23.

[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, COR had one vacant executive leadership positions, 2.5 primary care provider vacancies, 2.2 nursing supervisor vacancies, and 42 nursing staff vacancies.

Table 3. COR Health Care Staffing Resources as of April 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	11.5	24.2	181.6	222.3
Filled by Civil Service	4.0	9.0	22.0	139.6	174.6
Vacant	1.0	2.5	2.2	42.0	47.7
Percentage Filled by Civil Service	80.0%	78.3%	90.9%	76.9%	78.5%
Filled by Telemedicine	0	3.0	0	0	3.0
Percentage Filled by Telemedicine	0	26.1%	0	0	1.3%
Filled by Registry	0	0	0	38.0	38.0
Percentage Filled by Registry	0	0	0	20.9%	17.1%
Total Filled Positions	4.0	12.0	22.0	177.6	215.6
Total Percentage Filled	**80.0%**	**104.3%**	**90.9%**	**97.8%**	**97.0%**
Appointments in Last 12 Months	0	4.0	9.0	35.0	48.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	1.0	0	1.0	12.0	14.0
Adjusted Total: Filled Positions	**3.0**	**12.0**	**21.0**	**165.6**	**201.6**
Adjusted Total: Percentage Filled	**60.0%**	**104.3%**	**86.8%**	**91.2%**	**90.7%**

* 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 April 27, 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 COR'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. COR'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)—COR'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. COR had a 63 percent influenza immunization rate for adults 18 to 64 years old and a 67 percent influenza immunization rate for adults 65 years of age and older.[10] The pneumococcal vaccination rate was 72 percent.[11]

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. COR had a 67 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. COR Results Compared With State HEDIS Scores

HEDIS Measure	COR Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (>9.0%)‡,§	**10%**	38%	28%	20%
HbA1c Control (<8.0%)‡	82%	–	–	–
Blood Pressure Control (<140/90)‡	86%	–	–	–
Eye Examinations	53%	–	–	–
Influenza–Adults (18–64)	63%	–	–	–
Influenza–Adults (65+)	67%	–	–	–
Pneumococcal–Adults (65+)	72%	–	–	–
Colorectal Cancer Screening	67%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in May 2023 by reviewing medical records from a sample of COR's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 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 COR population was tested.

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

Source: Institutional 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 COR's performance, we offer the following recommendations to the department:

Access to Care

- Medical leadership should determine the root cause(s) of challenges in providing timely chronic care follow-up appointments, provider follow-up appointments after sick calls, and nurse-to provider referrals and should implement remedial measures as appropriate.

Diagnostic Services

- The department should consider developing strategies, such as an electronic solution, to ensure providers create patient notification letters at the time of review and endorsement, and patient notification letters contain all elements required per CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely provision, retrieval, and notification of STAT laboratory tests to providers and should implement remedial measures as appropriate.

- Medical leadership should determine the root cause(s) of challenges providers experience in timely reviewing and endorsing radiology reports and should implement remedial measures as appropriate.

Emergency Services

- Nursing leadership should determine the challenges with nurses completing assessments and documentation for all emergency and face-to-face encounters and should implement remedial measures as indicated.

Health Information Management

- Medical leadership should identify challenges in scanning, labeling, and including medical records in the correct patient's file and should implement remedial measures as appropriate.

Health Care Environment

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

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

- Executive leadership should determine the root cause(s) for staff not ensuring clinics and medical storage rooms are cleaned 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 and should implement remedial measures as appropriate.

Transfers

- Nursing leadership should determine the root cause(s) of challenges that prevent staff from completing thorough assessments of patients returning from hospitalizations and should implement remedial measures as appropriate.

- Health care leadership should identify the challenges pertaining to medication continuity for patients returning from hospitalizations or emergency room encounters and for patients en route who lay over at the institution; leadership should implement remedial measures as appropriate.

Medication Management

- Medical and nursing leadership should analyze the challenges in ensuring that chronic care, hospital discharge, and en route patients receive their medications timely and without interruption and should implement remedial leadership as appropriate.

- CCHCS should consider developing and implementing measures, such as a patient safety alert, in the medication administration record (MAR) when nurses administer incorrect insulin dosages.

Preventive Services

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

- Medical and nursing 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 root cause(s) of challenges that prevent nurses from performing complete assessments and should implement remedial measures, such as training staff, as appropriate.

- Nursing leadership should determine the challenges with scheduling symptomatic patient sick call requests for face-to-face evaluations to occur by the next business day after nurse review and should implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should determine the root cause of challenges that prevent nurses from completing thorough assessments and intervening appropriately when a change occurs in the patient's condition and should implement remedial measures as appropriate.

- Nursing leadership should determine the challenges in ensuring nurses initiate and document care plans in EHRS and should implement remedial measures as appropriate.[12]

- Medical, nursing, and pharmacy leadership should consider determining and evaluating causative factors related to the untimely provisions of medications and should implement remedial measures as appropriate.

Specialty Services

- Medical leadership should ascertain causative factors related to the untimely provision or scheduling of patients' specialty service appointments, including those of newly transferred patients with preapproved specialty referrals, and should implement remedial measures as appropriate.

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

[12] EHRS is the Electronic Health Records System. The department's electronic health record system is used for storing the patient's medical history and health care staff use this system to communicate.

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	***Inadequate* (68.9%)**

With case review, COR performed well in this indicator. We found COR staff completed most appointments as ordered, including chronic care, nurse-to-provider, clinic provider after hospitalization, clinic provider after specialty service, and specialized medical housing provider appointments. COR also performed well with access for nurse sick calls and provider-to-nurse referrals. The OIG rated the case review component of this indicator ***adequate.***

COR's performance in compliance testing was mixed. Access to providers was very good for newly transferred patients and for patients who returned to COR after a hospitalization. Nurses frequently reviewed patient sick call requests. However, staff performed poorly in completing chronic care provider appointments and nurse-to-provider referral. Access to provider follow-ups after specialty services also needed improvement. After analyzing all the factors, the OIG's rated the compliance component for this indicator ***inadequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed 415 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events requiring the institution to generate appointments. We found five deficiencies related to access to care.[13]

Access to Care Providers

Compliance testing showed completion of chronic care follow-up needed improvement (MIT 1.001, 62.5%). The institution also needed improvement in timely completion of nurse-to-provider and provider-ordered sick call follow-up appointments (MIT 1.005, 63.2%, MIT 1.006, 50.0%). The OIG clinicians reviewed 61 clinic provider appointments and identified the following two deficiencies:

[13] Deficiencies occurred in cases 2, 12, 22, 24, and 25.

- In case 2, a provider ordered a follow-up appointment with a provider to occur in 30 days; however, the appointment occurred in 43 days.

- In case 12, a provider ordered an appointment to occur within 39 days; however, the appointment occurred in 56 days.

Access to Specialized Medical Housing Providers

COR performed well with access to specialized medical housing providers. The OIG reviewed 60 provider encounters and identified the following deficiency:

- In case 25, the CTC patient was not seen by the provider for a weekly evaluation. Instead, the CTC patient was not seen by a provider for almost two weeks.

Access to Clinic Nurses

COR performed very well with access for nurse sick calls. Compliance testing showed most nurse sick call requests were reviewed on the same day they were received (MIT 1.003, 87.5%). However, the nurses had opportunities for improvement in evaluating their patients within the required one business day (MIT 1.004, 74.4%). OIG clinicians did not identify deficiencies related to clinic nurse access.

Access to Specialty Services

Compliance testing showed mixed performance in COR's completing specialty appointments. Less than half of the initial high-priority specialty appointments (MIT 14.001, 46.7%), but nearly all initial medium-priority and routine-priority specialty appointments (MIT 14.004, 93.3%, MIT 14.007, 93.3%) occurred within the required time frames. Compliance testing also showed mixed performance in follow-up specialty appointments (MIT 14.003, 85.7%, MIT 14.006, 100%, and MIT 14.009, 33.3%). OIG clinicians reviewed 49 specialty events and identified one minor deficiency related to a late routine-priority specialty appointment.[14]

Follow-Up After Specialty Services

COR showed fair performance in ensuring patients saw their providers after specialty appointments. Compliance testing revealed 74.4 percent of provider appointments after specialty services occurred within the required time frames (MIT 1.008). OIG clinicians did not identify any missed or delayed provider appointments.

Follow-Up After Hospitalization

COR performed excellently in ensuring patients saw their providers within the required time frames after hospitalizations. Compliance testing showed most provider appointments occurred within the required time frames (MIT 1.007, 90.9%).

[14] A deficiency occurred in case 24.

OIG clinicians reviewed 24 hospital returns and identified only one delayed provider appointment:

- In case 22, the patient returned from the community hospital, and the provider follow-up appointment did not occur within five calendar days of the return as the appointment was one day late.

Follow-Up After Urgent or Emergent Care (TTA)

Providers always saw their patients following a TTA event. OIG clinicians assessed 26 TTA events and did not identify any deficiencies.

Follow-Up After Transferring Into COR

COR performed well in ensuring provider appointments for newly arrived patients occurred within the required time frames (MIT 1.002, 84.0%). Our clinicians evaluated four transfer-in events and did not identify any missed or delayed provider appointments.

Clinician On-Site Inspection

COR had six main clinics, each staffed with one provider and one office technician, both of whom attended the morning huddles and ensured provider appointments occurred. Each provider saw about 12 patients per day. At the time of the on-site inspection, the clinic backlog across all clinics was about 100 provider appointments.

Our clinicians discussed delayed appointments with the office technician supervisor, who acknowledged the delays were mainly due to a lack of providers. To address the backlog, providers occasionally saw clinic patients during the weekends.

Compliance On-Site Inspection

Two of the six housing units randomly tested during our inspection had access to Health Care Services Request Forms (CDCR form 7362) (MIT 1.101, 33.3%). In four housing units, custody officers did not have a system in place for reordering the request forms. According to custody officers, they relied on medical staff to replenish the request forms in the housing units.

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)	15	9	1	62.5%
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)	21	4	0	84.0%
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)	29	10	1	74.4%
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)	12	7	21	63.2%
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	1	38	50.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	10	1	0	90.9%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	29	10	6	74.4%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	2	4	0	33.3%
				Overall percentage (MIT 1): **68.9%**

* 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)	13	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)	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	6	1	8	85.7%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	12	0	3	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	2	4	9	33.3%

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges in providing timely chronic care follow-up appointments, provider follow-up appointments after sick calls, and nurse-to provider referrals and should implement remedial measures as appropriate.

Diagnostic Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (48.3%)**

Case review found COR performed well in diagnostic services. Staff often completed timely radiology and laboratory tests, including STAT laboratory tests. Staff also performed well in retrieving diagnostic and laboratory tests but did not retrieve all pathology reports. Providers frequently endorsed both radiology and laboratory tests but sporadically sent complete patient test result notification letters. Factoring all the findings, OIG rated the case review component of this indicator ***adequate***.

COR's overall compliance testing scored low for this indicator. Staff performed exceptionally in completing radiology tests. However, staff only sometimes completed laboratory tests and never completed STAT tests within the required time frames. Providers promptly endorsed diagnostic results but rarely generated patient test result letters with all required elements. Consequently, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 213 diagnostic events and identified 66 deficiencies, five of which were significant. Of the 66 deficiencies, we found 61 related to health information management, four related to test completion, and one pertaining to the patient care environment.[15]

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

Test Completion

COR performed excellently in completing radiology tests. Compliance testing showed staff completed all radiology tests within the requested time frames (MIT 2.001, 100%). Similarly, our clinicians reviewed 14 imaging studies and found no deficiencies related to radiology test completion.

[15] Diagnostic deficiencies occurred in cases 1, 2, 8–17, 19–21, and 23.
Significant deficiencies occurred in cases 8–10, 14, and 23.

COR performed variably in completing laboratory tests. Compliance sampling showed less than half of laboratory tests were completed timely (MIT 2.004, 40.0%). Case reviewers found somewhat better results but identified four deficiencies related to untimely specimen collection, three of which were minor.[16] The one significant deficiency is described below:

- In case 14, a provider requested a urine toxicology test to be collected on the following day. However, staff did not collect the urine until six days later.

STAT laboratory test completion results differed between compliance testing and case review. Compliance testing showed all four of their STAT laboratory sample tests were not performed within the required time frame (MIT 2.007, zero). In contrast, the case reviewers found all three of their STAT laboratory sample tests were completed on time.[17] The case reviewers also found staff timely completed a STAT chest x-ray and a STAT electrocardiogram.[18]

Health Information Management

Although COR staff retrieved most diagnostic results promptly, OIG case reviewers found four instances of missed or delayed retrievals; two involved STAT laboratory results and two involved pathology reports. These four deficiencies are listed below:

- In case 9, COR staff obtained a STAT basic metabolic laboratory test. However, OIG case reviewers found no documentation indicating the nurse informed the provider of the laboratory result within four hours after the test was requested for pick-up. EHRS showed the provider endorsed the result three days later.

- In case 10, COR staff obtained a STAT basic metabolic laboratory test. However, OIG case reviewers found no documentation indicating the nurse informed the provider of the laboratory result within four hours after the test was requested for pick-up. EHRS showed the provider endorsed the result the following day.

- In case 8, the patient underwent a liver biopsy; staff retrieved the preliminary pathology report but did not retrieve the final report.

- In case 23, the patient underwent a biopsy of a spinal lesion. The pathology report was available two days later; however, the institution did not retrieve the report until 27 days later.

Compliance testing showed COR staff did not notify providers of STAT laboratory results within the required time frame (MIT 2.008, zero) but often retrieved pathology reports timely (MIT 2.010, 80.0%).

Compliance testing showed providers only intermittently endorsed radiology reports timely (MIT 2.002, 50.0%), but providers often endorsed laboratory results timely (MIT

[16] Deficiencies occurred in cases 1, 12, and 14. A significant deficiency occurred in case 14.

[17] STAT laboratory tests occurred in cases 9, 10, and 22.

[18] A STAT chest x-ray was completed in case 21. A STAT electrocardiogram was completed in case 1.

2.005, 80.0%). Providers always endorsed pathology reports (MIT 2.011, 100%) and STAT laboratory results (MIT 2.009, 100%). Our case review clinicians also found providers almost always endorsed test results quickly, with only two minor late endorsements.[19]

Providers consistently erred in communicating results to patients through complete and proper test result letters. OIG case reviewers found 51 examples of patient test result notification letters missing at least one of the required elements and five examples in which the providers did not send a patient notification letter. Compliance testing showed similar results. Specifically, providers rarely sent timely patient notification letters for laboratory results (MIT 2.006, 20.0%) and radiology reports (MIT 2.003, 10.0%), and providers never sent timely pathology results (MIT 2.012, zero).

Our clinicians identified one deficiency in which a radiology technician documented a patient refusal but did not notify the provider.[20]

Clinician On-Site Inspection

OIG clinician inspectors met with diagnostic supervisors and staff. COR provides on-site laboratory and general x-ray services, as well as on-site ultrasound, CT, and MRI imaging.[21] Despite multiple staff members mentioning staffing vacancies in both the laboratory and radiology departments, supervisors reported no backlog at the time of our inspection. The laboratory supervisor detailed the process for STAT tests, stating the four-hour window for results begins when the STAT test specimen is picked up by the contracted vendor.[22] Laboratory staff would begin calling for test results approximately two and a half hours later, and every hour thereafter until results are available. If the test results were not available when the laboratory closed, laboratory personnel were expected to relay this information to a CTC or TTA RN, depending on the patient's housing location. Laboratory staff or nursing staff logged contacts with the vender for STAT test results in a public folder.

[19] Deficiencies occurred in cases 8 and 16.

[20] This deficiency occurred in case 15.

[21] A CT scan is a computed, or computerized, tomography imaging scan. An MRI is a magnetic resonance imaging scan.

[22] Per the HCDOM 3.1.14.c.2.H, STAT results shall be provided by the contracted laboratory via telephone to the Triage and Treatment Area (TTA), or designated health care team member, within four hours of the telephone request for pick-up for nonrural institutions and five hours for rural institutions. https://cchcs.ca.gov/wp-content/uploads/sites/60/HC/HCDOM-ch03-art1.14.pdf

Compliance Testing Results

Table 7. Diagnostic Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	5	5	0	50.0%
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)	4	6	0	40.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	8	2	0	80.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	2	8	0	20.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	0	4	0	0
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	0	4	0	0
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	4	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **48.3%**

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

Recommendations

- The department should consider developing strategies, such as an electronic solution, to ensure providers create patient notification letters at the time of review and endorsement, and patient notification letters contain all elements required per CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely provision, retrieval, and notification of STAT laboratory tests to providers and should implement remedial measures as appropriate.

- Medical leadership should determine the root cause of challenges experienced by providers in timely reviewing and endorsing radiology reports and should implement remedial measures as appropriate.

Emergency Services

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

Ratings and Results Overview

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

COR provided sufficient care in emergency services. Staff generally delivered prompt cardiopulmonary resuscitation during medical emergencies. Nurses and providers performed adequate evaluations for patients and delivered appropriate interventions. The EMMRC generally identified deficiencies in emergency services and training needs during its emergency clinical review process. The OIG rated this indicator ***adequate.***

Case Review Results

We reviewed 27 urgent and emergent events and found 25 emergency care deficiencies. Of these 25 deficiencies, nine were significant.[23]

Emergency Medical Response

COR custody and health care staff responded promptly to emergencies throughout the institution. They timely activated emergency medical services, performed CPR, and notified TTA staff. Below is an example of good CPR:

- In case 3, the LVN entered the patient's room and found the patient pale, unresponsive, and not breathing. The nurse lowered the head of the bed, initiated CPR, requested custody to call 9-1-1, and activated the emergency response team. Nursing staff inserted an interosseous access in the left shoulder to administer fluids and emergency medication, applied an automated external defibrillator (AED), and continued emergency treatment until emergency medical services arrived.[24]

[23] Deficiencies occurred in cases 1, 2, 4, 5, 8, 17, and 19–22. Significant deficiencies occurred in cases 8, 19, 21, and 22.

[24] Interosseous access involves inserting a catheter into bone in order to provide medication or fluids. Health care staff perform this procedure when intravenous access is not available.

Provider Performance

Providers usually made appropriate decisions for patients. On-call providers were available for consultations and documented their telephone calls with nurses. We identified three deficiencies, one of which was considered significant.[25] The significant deficiency is discussed in the **Provider Performance** indicator.

Nursing Performance

Nurses generally provided good care; however, our clinicians identified opportunities for improvement in the areas of nursing assessment, interventions, and documentation. Below are examples:

- In case 2, TTA nurses assessed the patient for chest pressure not relieved with nitroglycerin. The TTA RN did not complete a thorough cardiovascular or abdominal assessment. The nurse did not listen to lung or bowel sounds and did not palpate the patient's abdomen.

- In case 21, the patient complained of abdominal pain. The psychiatric technician (PT) notified the TTA RN of the patient's abdominal pain and elevated blood pressure. The TTA RN advised the PT to have the patient transported to TTA with custody via wheelchair prior to any further nurse assessment, which delayed a nurse assessment of the patient.

Nursing Documentation

Nurses in the TTA usually performed thorough documentation for emergent events.

Emergency Medical Response Review Committee

Our clinicians found the EMRRC met monthly to review emergency response cases. We identified five deficiencies, including two significant deficiencies in one case.[26] In this case, the supervising registered nurse (SRN) did not identify deficiencies in assessments and documentation.

Compliance testing showed EMRRC often reviewed cases timely (MIT 15.003, 83.3%).

Clinician On-Site Inspection

During our clinician inspection, we toured the TTA and interviewed the TTA nurses. COR has three TTA bays, which provide space for emergency care. Staff uses two bays for urgent or emergent care and one bay for treatments. The TTA nurses mentioned two nurses report on each shift. Additionally, COR assigns a provider to the TTA Monday–Friday from 8 a.m. to 5 p.m. Outside of these hours, on weekends, and on holidays, nurses contact the on-call provider for assistance.

[25] Deficiencies occurred in cases 19, 21, and 22. A significant deficiency occurred in case 22.

[26] Deficiencies occurred in cases 5, 8, and 19-21. Significant deficiencies occurred in cases 8 and 19.

Recommendations

- Nursing leadership should determine the challenges with nurses in completing assessments and documentation for all emergency and face-to-face encounters and should implement remedial measures as indicated.

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
Adequate	***Inadequate* (68.1%)**

Case review found COR managed health information well. Staff documented emergency care events excellently, and providers often endorsed reports timely. Staff retrieved most hospital records timely but did not retrieve all specialty service records timely. OIG clinicians also identified many incomplete or missing patient notification letters, as well as some scanning errors. After careful consideration, the OIG rated the case review component of this indicator ***adequate.***

COR's compliance testing performance was mixed. Staff always scanned patients' requests for medical care. They also retrieved most hospital records and specialty reports within the requested time frames. However, compliance testing showed many patient notifications letters were incomplete or missing, and staff did not properly scan, label, or file medical documents. Taking all results into consideration, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 887 events and found 83 deficiencies related to health information management. Of these 83 deficiencies, 11 were significant.[27]

Hospital Discharge Reports

Staff performed well in retrieving hospital records within the required time frame. OIG clinicians reviewed 24 off-site emergency department and hospital encounters and identified only one retrieval deficiency:

- In case 19, the patient returned to the institution after a hospitalization. However, COR staff did not retrieve the preliminary discharge summary until eight days later.

[27] Deficiencies occurred in cases 2, 8, 9–14, 16– 24, and 35. Significant deficiencies occurred in cases 8, 9, 10, 19, and 22–24.

We also identified a deficiency related to the late provider endorsement of a discharge summary:

- In case 8, a provider endorsed the patient's emergency department discharge summary 14 days late.

Compliance testing showed satisfactory results with hospital discharge report retrieval (MIT 4.003, 81.8%), and reports generally included key elements and provider endorsements within required time frames (MIT 4.005, 81.8%).

Specialty Reports

COR did not perform as well in managing specialty reports. Our clinicians reviewed 49 specialty reports and identified 14 deficiencies, five of which were significant. Three of the five significant deficiencies were for not retrieving records from a specialty consultation, as illustrated in the cases below:

- In case 22, a telemedicine neurologist evaluated the patient. However, COR staff did not retrieve or scan this specialist's report into EHRS.

- In case 24, a neurosurgeon evaluated the patient. COR staff retrieved the handwritten note from the neurosurgeon but did not retrieve the formal dictated report.

- In case 24, an off-site ophthalmologist evaluated the patient. However, COR staff did not scan this specialist's report into the EHRS.

We identified one deficiency with COR staff scanning a neuromuscular study report late.[28]

Compliance testing showed satisfactory performance in retrieving and scanning specialty documents (MIT 4.002, 76.7%). However, COR needed improvement in retrieval and provider endorsements of high-priority (MIT 14.002, 66.7%), medium-priority (MIT 14.005, 60.0%), and routine-priority (MIT 14.008, 66.7%) specialty reports. Case reviewers also identified late endorsements in the following cases:

- In case 8, a provider endorsed a PET scan report eight days late.[29]

- In case 13, an endocrinologist responded to an electronic consultation request. A provider did not review the response until a week later.

Diagnostic Reports

Our clinicians reviewed 213 diagnostic events and identified 61 deficiencies, two of which were significant and involved the retrieval of STAT laboratory results. These cases are discussed in the **Diagnostic Services** indicator in more detail. Of the remaining 59

[28] This deficiency occurred in case 24.

[29] A positron emission tomography (PET) scan is an imaging test of organs and soft tissues.

deficiencies, 57 involved incomplete or missing patient notification letters, none of which were significant but clearly demonstrated a pattern.

We identified only two minor deficiencies of late provider endorsements. Likewise, compliance testing showed providers performed excellently at endorsing STAT laboratory results (MIT 2.009, 100%) and pathology reports (MIT 2.011, 100%) within the required time frames. Providers performed satisfactorily with laboratory endorsements (MIT 2.005, 80.0%) but needed improvement with radiology endorsements (MIT 2.002, 50.0%).

Please refer to the **Diagnostic Services** indicator for additional information.

Urgent and Emergent Records

OIG clinicians reviewed 26 emergency care events and found no documentation deficiencies. Both the nurses and providers recorded these events excellently.

Scanning Performance

Case reviewers identified six deficiencies related to mislabeled or misfiled medical documents, none of which were significant.[30] The following are examples:

- In case 8, a provider completed a history and physical note for a CTC admission. However, the note was mislabeled as an inpatient progress note.
- In case 18, a cardiothoracic surgery specialty report was mislabeled as a cardiology consultation.
- In case 19, the patient was evaluated at an outside hospital. However, the cover page of the hospital record stated the patient was seen at a different hospital.

Compliance testing showed COR performed excellently in scanning patient health care request forms (MIT 4.001, 100%). However, COR never properly scanned, labeled, or filed other medical documents (MIT 4.004, zero).

Clinician On-Site Inspection

At the on-site inspection, OIG clinicians discussed health information management processes with the COR medical leadership, health information management supervisors, utilization management staff, office technicians, and providers. Staff reported having approximately 300 off-site specialty appointments per month and up to 25 per day. This large volume had been challenging for the medical record staff. They developed a tracking tool for unretrieved specialty documents and diagnostic results. We also spoke to medical leadership and the providers regarding patient notification letters and the elements required by CCHCS policy. Many providers reported feeling a "task burden," because of the many and various documentation duties expected of providers. The chief

[30] Deficiencies occurred in cases 8, 11, 17–19, and 35.

physician and surgeon (CP&S) had developed a "tip sheet" as a reminder to providers regarding the required elements of a patient notification letter.

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)	23	7	15	76.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	9	2	0	81.8%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	0	24	0	0
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	9	2	0	81.8%
				Overall percentage (MIT 4): **68.1%**

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

Table 9. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	5	5	0	50.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	8	2	0	80.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	0	4	0	0
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	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)	10	5	0	66.7%
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)	9	6	0	60.0%
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)	10	5	0	66.7%

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

Recommendations

- Medical leadership should identify challenges in scanning, labeling, and including medical records in the correct patient's file 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* (52.4%)**

In this cycle, multiple aspects of COR's health care environment were poor: medical supply storage areas inside clinics either contained expired medical supplies, compromised sterile medical supply packaging, or medical supplies stored directly on the floor; several areas of the examination rooms were unsanitary; 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 properly wash their hands throughout the patient encounters. These factors resulted in an ***inadequate*** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

We examined outdoor patient waiting areas (see Photo 1). Health care and custody staff reported the existing waiting areas had enough seating capacity and ample protection from inclement weather.

Photo 1. Outdoor waiting area with ample protection from inclement weather (photographed on 5-9-23).

Indoor Waiting Areas

We inspected indoor waiting areas. Health care and custody staff reported the existing waiting areas contained sufficient seating capacity. Dependent on the population, patients were either placed in the clinic waiting area or held in individual modules (see Photos 2 and 3, next page). During our inspection, we did not observe overcrowding or noncompliance with social distancing requirements in any of the clinics' indoor waiting areas.

Photo 2. Indoor waiting area (photographed on 5-10-23).

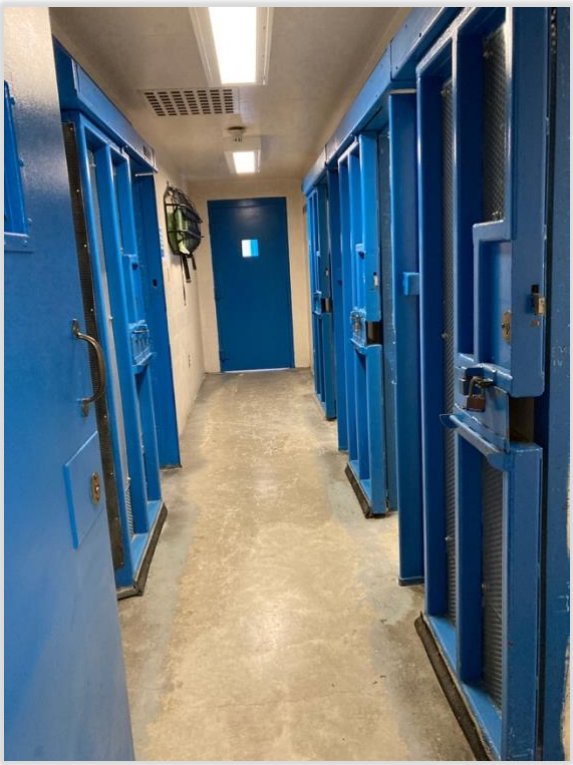


Photo 3. Indoor waiting area (photographed on 5-10-23).

Clinic Environment

Thirteen of 14 clinic environments were sufficiently conducive for medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 92.9%). In one clinic, the blood draw stations were within close proximity to each other, which hindered auditory privacy.

Of the 14 clinics we observed, 10 contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 71.4%). In the remaining four clinics, we observed one or more of the following deficiencies: torn examination chairs and physical therapy equipment; examination room configurations lacking visual privacy for conducting clinical examination or room configurations that did not allow patients to lie fully extended on the examination table without obstructions (see Photos 4 and 5); and clinics with unsecured confidential medical records.

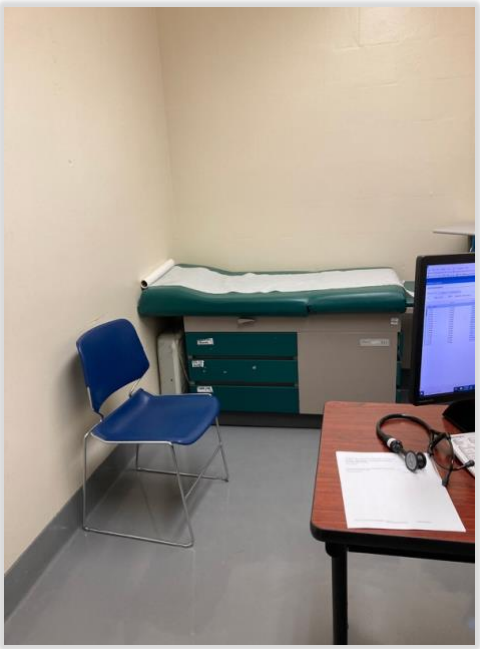


Photo 4. Examination room configuation prevented patients from fully reclining (photographed on 5-9-23).

Photo 5. Examination room configuation prevented patients from fully reclining (photographed on 5-9-23).

Clinic Supplies

Only two of the 14 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 14.3%). We found one or more of the following deficiencies in 12 clinics: compromised sterile medical supply packaging; long-term storage of staff's food in the medical supply storage room (see Photo 6); expired medical supplies (see Photo 7); unorganized, unidentified, or inaccurately labeled medical supplies; cleaning materials stored with medical supplies; and medical supplies directly stored on the floor.

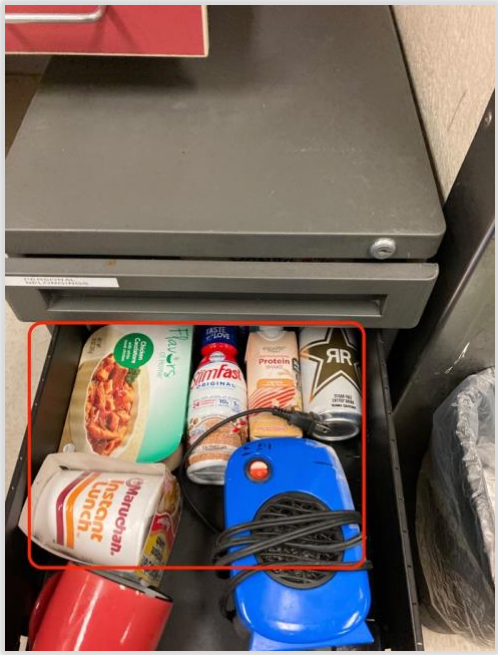
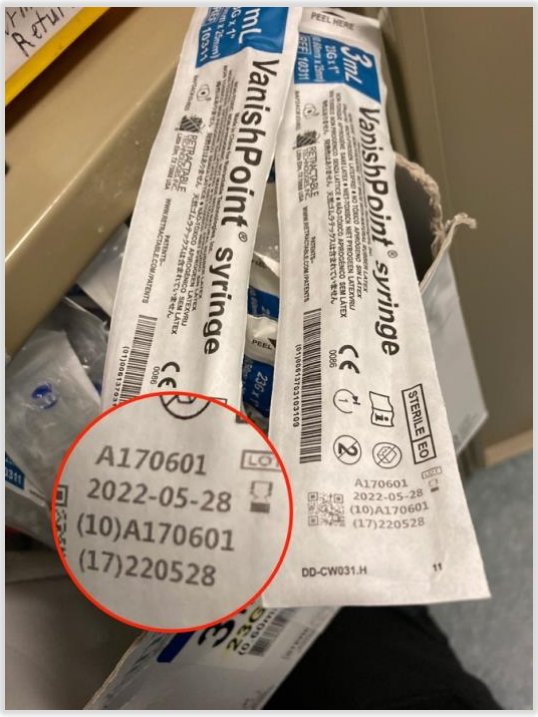


Photo 6. Long-term storage of staff food in the medical supply room (photographed on 5-10-23).



Only two of the 14 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 14.3%). The remaining 12 clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included: examination table paper, lubricating jelly, tongue depressors, otoscope tips, and a nebulization unit. In several clinics, staff had not properly calibrated an automated vital signs machine, a weight scale, or a nebulization unit, and two clinics contained a nonfunctional oto-ophthalmoscope. Also, staff did not complete the AED or defibrillator performance test log documentation within the last 30 days. In addition, most clinic daily glucometer quality control logs were either inaccurate or incomplete.

Photo 7. Expired medical supplies dated 5-28-22 (photographed on 5-10-23).

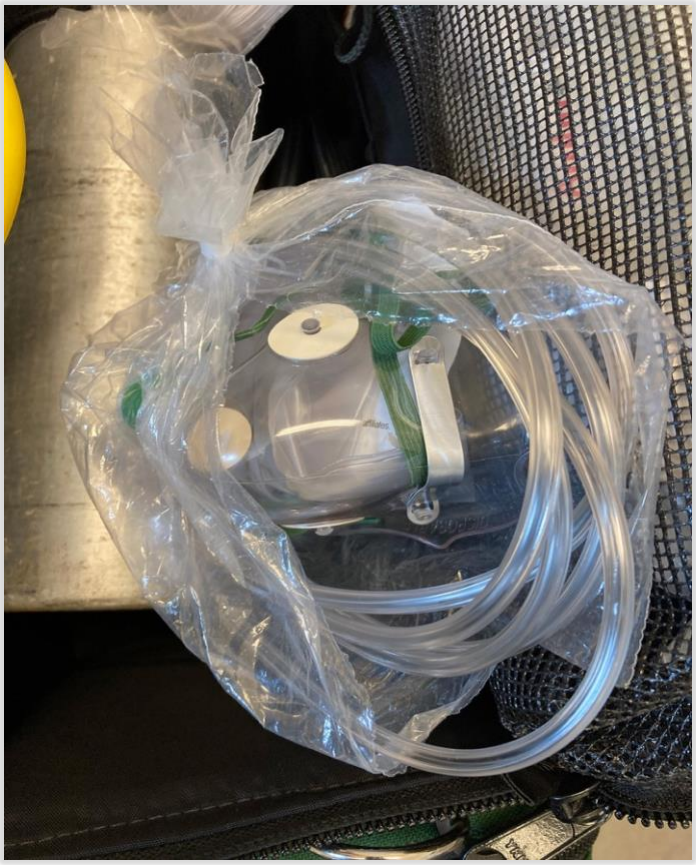


Photo 8. Compromised EMRB medical supply
(photographed on 5-9-23).

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only two of the 11 EMRBs passed our test (MIT 5.111, 18.2%). In nine EMRBs, we found one or more of the following deficiencies: staff failed to ensure EMRB compartments were sealed and intact; staff failed to complete the log documentation; staff had not inventoried EMRBs when the seal tags were replaced; staff either logged EMRB daily glucometer quality control results incompletely or inaccurately; and two EMRBs contained compromised medical supplies (see Photo 8). In addition, the treatment carts in the TTA contained compromised medical supplies.

Medical Supply Management

COR staff always stored clinic medical supplies in the medical supply storage areas outside the clinics (e.g., warehouse, Conex containers, etc.) (MIT 5.106, 100%). According to the chief executive officer (CEO), the institution did not have any issues with the medical supply process. Health care and warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system in place.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected seven of 14 clinics (MIT 5.101, 50.0%). In seven clinics, we found one or more of the following deficiencies: cleaning logs were not maintained, biohazard waste was not emptied after each clinic day; a cabinet under the clinic sink was unsanitary (see Photo 9), and a clinic floor was unsanitary.

Staff in three of 10 applicable clinics (MIT 5.102, 30.0%) properly sterilized or disinfected medical equipment. For seven clinics, staff did not mention disinfecting the exam table as part of their daily start-up protocol. Additionally, in two of the seven clinics, the nurse did not disinfect the reusable medical equipment after each patient encounter.

Photo 9. Unsanitary cabinet under the clinic sink (photographed on 5-10-23).

We found operating sinks and hand hygiene supplies in the examination rooms in 12 of 14 clinics (MIT 5.103, 85.7%). In one clinic, the patient restroom lacked antiseptic soap. In another clinic, the patient restroom lacked disposable hand towels.

We observed patient encounters in seven applicable clinics. In all seven clinics, clinicians did not properly wash their hands throughout the patient encounters (MIT 5.104, zero).

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 our medical inspection, the institution reported the health care facility improvement program had ongoing construction projects to renovate the 3B clinic and build a new correctional treatment center and standby emergency room. The institution estimated the projects would have been completed by June 2023. In addition, the institution reported construction had been delayed for renovations of the 3A and 4A clinics and construction of a new medication distribution room in 4B due to pending fire marshal approval. The institution was not able to provide an estimated completion date at the time of our inspection.

Despite the delay of the renovation of the 3A and 4A clinics and the construction of the new medication distribution room in 4B, the CEO did not believe the institution's current ability to provide good patient care (MIT 5.999) had been negatively impacted.

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)	7	7	1	50.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	3	7	5	30.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	12	2	1	85.7%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	0	7	8	0
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	14	0	1	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	1	0	1	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	2	12	1	14.3%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	2	12	1	14.3%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	13	1	1	92.9%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	10	4	1	71.4%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	2	9	4	18.2%
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): **52.4%**

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

Recommendations

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

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

- Executive leadership should determine the root cause(s) for staff not ensuring clinics and medical storage rooms are cleaned 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 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
Inadequate	***Inadequate* (72.3%)**

Case review found that COR needed improvement in the transfer process. For patients transferring into and out of the institution, the clinicians found nursing assessments were good. However, COR continued to struggle with completing detailed nursing screenings for patients who transferred out of COR and thorough assessments for patients who returned from hospitalizations or emergency room encounters. COR also struggled to ensure patients returning from the hospital did not have lapses in their medication continuity. Factoring in all the information, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed mixed results with the transfer process. Nurses often completed screenings and assessments for newly arrived patients. Newly arrived patients and hospital discharge patients also were evaluated by their providers timely. Staff retrieved and scanned complete hospital discharge reports timely. However, staff needed improvement in providing medications for patients who transferred into COR, patients who transferred between COR housing units, patients en route, and patients who transferred out with complete transfer packages. Staff performed poorly in ensuring medication continuity after hospital discharge. Factoring all compliance test scores, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 40 events in 16 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 30 deficiencies, nine of which were significant.[31]

Transfers In

Compliance testing showed nurses always completed the assessment and disposition section of the forms (MIT 6.002, 100%). Compliance testing also showed the receiving and release (R&R) nurses sufficiently completed the initial health screening forms (MIT 6.001, 76.0%). The clinicians reviewed four transfer-in cases and found nurses performed very well completing assessments and ordering the initial provider appointments within required time frames. We identified one minor deficiency in nursing documentation.

Compliance testing showed staff performed well with ensuring newly arrived patients were seen by a provider within required time frames (MIT 1.002, 84.0%). Similarly, case review found excellent performance with timeliness of provider appointments for newly arrived patients as our clinicians did not identify any deficiencies.

Compliance testing showed poor medication continuity of transfer-in patients (MIT 6.003, 46.7%). In case review, we identified two deficiencies, the following one of which was significant:[32]

- In case 26, the patient with a medical history of hypertension and degenerative joint disease arrived at COR. The patient did not receive the morning medications for pain and hypertension until the afternoon.

Compliance testing showed staff performed poorly in scheduling preapproved specialty appointments for patients who transferred into the institution (MIT 14.010, 40.0%). Analysis of the compliance data showed COR staff did not timely schedule specialty appointments and did not ensure refusal forms were scanned into the patient's electronic health care record. However, case review found that specialty appointments for newly arrived patients occurred timely.

Transfers Out

COR's transfer-out process had mixed results for case review and compliance testing. Our case review clinicians reviewed nine events and identified four deficiencies; none were significant. Nursing staff always performed COVID-19 point-of-care (POC) testing and performed adequate transfer-out screenings when the patient transferred from COR.

In contrast, COR scored low with compliance testing in the three applicable samples as nurses needed improvement in ensuring patients transferred out of COR with their medications and required documentation (MIT 6.101, 66.7%). The clinicians also found

[31] Deficiencies occurred in cases 1, 2, 8, 9, 19–22, 25, and 28–31. Significant deficiencies occurred in cases 2, 8, and 19–22.

[32] Deficiencies occurred in cases 2 and 26. A significant deficiency occurred in case 26.

COR performed poorly in medication continuity for patients transferring out of the institution. Below are examples:

- In case 29, the transfer RN did not ensure the patient received the morning dose of aspirin prior to transfer.

- In case 30, the transfer RN did not ensure the patient received the morning dose for two blood pressure medications prior to transfer.

Hospitalizations

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

Our clinicians reviewed 24 events in which patients returned from a hospitalization or emergency room evaluation and identified 23 deficiencies, eight of which were significant.[33] Nurses often performed incomplete assessments when patients returned from the hospital or emergency room. The following is an example:

- In case 20, the patient returned from a hospital admission for left extremity skin infection. Prior to the patient's return to the institution, the utilization management (UM) RN documented the patient would require daily dressing changes and ambulation with a front-wheel walker.[34] The RN who assessed the patient upon return to the institution did not assess the patient's left lower extremity or gait, initiate wound care orders, or document the time of the provider consultation.

We also identified incomplete hospitalization or emergency room nursing assessments performed by nurses in SMH. For more information, see the **Specialized Medical Housing Indicator.**

Compliance testing showed that COR performed poorly in medication continuity for patients who returned to the institution after discharge from the community hospital (MIT 7.003, 36.4%). Our clinicians identified seven deficiencies in six cases related to medication continuity, three of which were significant.[35] The following are examples:

- In case 8, the patient with a history of hypertension, diabetes, and high cholesterol returned from the community hospital. On the patient's return to

[33] Deficiencies occurred in cases 1, 8, 9, and 19–22. Significant deficiencies occurred cases 8, 19, and 20-22.

[34] A utilization management nurse assists in ensuring 'the appropriate use of limited health care resources including, but not limited to, medical procedures, consultations with specialists, diagnostic studies, inpatient beds, and outpatient beds allocated for health program use to promote the best possible patient outcomes, eliminate unnecessary cost, and maintain consistency in the delivery of health care services' consistent with the stated goals of HCDOM section 1.2.15 Utilization Management Program.

[35] Deficiencies occurred in cases 1, 8, 9, 19, and 21–22. Significant deficiencies occurred in cases 8 and 21.

COR, staff reconciled some of his medications but not all. This led to lapses in continuity of multiple blood pressure medications and aspirin.

- In case 20, the patient with a history of COPD, hyperlipidemia, and acid reflux disease returned from the community hospital with a diagnosis of left leg cellulitis. The patient received the chronic care medications for hypertension, cholesterol, and acid reflux three days late. Also, the patient did not receive the rescue inhaler medication for almost two months.

- In case 21, the patient returned from a hospitalization for appendicitis and did not receive his chronic medications, as all medications were not reconciled upon his return to the institution, causing a delay in medication continuity. Three days later, the UM RN reviewed the hospital discharge summaries and notified the providers about medications that had not been reordered. Some of the patient's medications were ordered; however, the patient did not receive some mental health medications until eight days after returning from the hospital.

Compliance testing showed excellent performance for timely provider follow-up appointments (MIT 1.007, 90.9%), along with the scanning and completeness of the hospital discharge summaries (MIT 4.003, 81.8% and MIT 4.005, 81.8%). Our clinicians found most documents were scanned timely with only two significant deficiencies.[36]

Clinician On-Site Inspection

At the on-site inspection, our clinicians interviewed nursing leadership, R&R nurses, and pharmacy staff regarding the transfer-in and transfer-out processes, including medication availability. The R&R nursing staff were very knowledgeable about these processes. Nursing leadership and pharmacy staff reported, when patients transferred out of the institution, they were sent with a seven-day supply of medications that were not listed on the licensed correctional clinic list.

Nursing staff reported the TTA and R&R nurses reconciled medications for patients who returned to the institution after a hospitalization. In addition, they would give hospital discharge information to the medication nurses who review the medications. The medication nurses would call the on-call provider as needed and notify the patient care team when medications arrived.[37] The provider messaged the patient care teams when the medication reconciliation was complete.

[36] Deficiencies occurred in cases 8 and 19. Significant deficiencies occurred in both cases.

[37] The patient care team includes providers, nurses, and support 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)	19	6	0	76.0%
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)	25	0	0	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)	7	8	10	46.7%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	2	1	2	66.7%
				Overall percentage (MIT 6): **72.3%**

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

Table 12. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	21	4	0	84.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	10	1	0	90.9%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	9	2	0	81.8%
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	2	0	81.8%
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)	4	7	0	36.4%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	16	9	0	64.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006)	5	3	0	62.5%
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)	8	12	0	40.0%

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

Recommendations

- Nursing leadership should determine the root cause(s) of challenges that prevent staff from completing thorough assessments of patients returning from hospitalizations and should implement remedial measures as appropriate.

- Health care leadership should identify the challenges pertaining to medication continuity for patients returning from hospitalizations or emergency room encounters and for patients en route who lay over at the institution; leadership should implement remedial measures as appropriate.

Medication Management

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. 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
Inadequate	***Inadequate* (41.7%)**

Case review found COR performed poorly overall in this indicator as we found more deficiencies in this Cycle 7 compared to Cycle 6. Although COR usually provided specialized medical housing and transfer patients their medications, COR needed improvement with managing new medications, chronic care medications, medications for patients returning from the hospital, and insulin for diabetic patients. After considering all factors, the OIG rated the case review component of this indicator ***inadequate.***

Compliance testing similarly showed COR needed improvement with this indicator. COR scored low in providing patients with chronic care medications, newly prescribed medications as ordered, community hospital discharge medications, and medications for patients temporarily housed at the institution as well as medication continuity for patients transferring within the institution. Considering all testing results, the OIG rated the compliance testing component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 112 events in 26 cases involving medications and found 46 medication deficiencies, 12 of which were significant.[38]

New Medication Prescriptions

Compliance testing showed a pattern of delays in the availability of newly ordered medications (MIT 7.002, 72.0%). Our clinicians found a similar pattern and identified 10 deficiencies, two of which were significant. The following are two examples:

[38] Deficiencies occurred in cases 1, 2, 4, 8–11, 13, 14, 16, 18–23, 26, 29, 30, and 38. Significant deficiencies occurred in cases 2, 8, 11, 20, 21, and 23.

- In case 11, the provider ordered two new medications to treat the patient's diabetes. However, the patient did not receive both medications during the month they were ordered.

- In case 23, the patient received his newly prescribed medication to treat prostate cancer 14 days late.

Chronic Medication Continuity

Compliance testing showed patients' chronic care medications were rarely available within required time frames, pharmacy did not fill and dispense the medication timely, and nurses did not follow policy for documenting refusals (MIT 7.001, 9.5%). Our clinicians found 10 cases with lapses in chronic care medication continuity.[39] The following cases provide examples:

- In case 2, the patient received nitroglycerin KOP PRN medication twice within a seven-day period.[40] On a separate occasion, the patient did not receive an automatic refill of medication to treat a prostate condition during February 2023.

- In case 11, the patient did not receive blood pressure medication for the month of October 2022. The patient received the 30-day supply the following month.

- In case 21, due to a delay in the timely refill of the patient's prescribed seizure medication, after the current prescription was completed, the patient experienced a seven-day lapse in medication continuity during the month of November 2022.

Hospital Discharge Medications

Compliance testing showed patients returning from hospitals or emergency rooms only sporadically received their medication within the required time frames (MIT 7.003, 36.4%). Similarly, our clinicians found seven deficiencies related to missed doses of medication when patients returned from the hospital.[41] For further details, please refer to the **Transfers** indicator.

Specialized Medical Housing Medications

Compliance testing showed newly admitted patients sporadically received their medications within ordered time frames (MIT 13.003, 38.5%). In contrast, our clinicians found most patients received their medications timely.[42]

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[39] Patients did not receive timely chronic care medications in cases 1, 2, 10, 11, 16, and 19–23. Significant deficiencies occurred in cases 2, 11, 21, and 23.

[40] KOP means "keep on person" and refers to medications in which a patient can keep and self-administer according to the directions provided. PRN means "as needed" and the patient can take a medication as needed according to the directions provided. A medication can be ordered as both KOP and PRN.

[41] Deficiencies occurred in cases 1, 8, 9, and 19–22. Significant deficiencies occurred in cases 8 and 20.

[42] Deficiencies occurred in cases 19 and 22.

Transfer Medications

Compliance testing showed COR performed poorly in medication continuity for patients arriving from other institutions (MIT 6.003, 46.7%). In contrast, our clinicians identified only one significant deficiency for medication continuity.[43] When patients had layovers or were temporarily housed at COR, nurses intermittently administered medications within the institution's required time frames (MIT 7.006, 62.5%). When patients transferred between housing units within the institution, compliance testing showed nursing staff frequently did not document the reason for refusal of medications or the reason for any identified barriers to the medication line (MIT 7.005, 64.0%). Our clinicians found one minor deficiency in documentation of KOP medication.

Medication Administration

COR performed satisfactorily in ensuring tuberculosis (TB) medication continuity (MIT 9.001, 81.3%). However, the institution poorly monitored patients on TB medications (MIT 9.002, 31.3%). Our clinicians also identified three cases in which nurses did not make appropriate decisions regarding insulin administration.[44]

- In case 8, on three separate occasions during the review period, the nurses gave regular insulin without checking the patient's blood sugar levels.

- In case 13, the patient had an order for sliding scale insulin.[45] On one date, the nurse administered insulin prior to checking the patient's blood sugar. Also, the medication nurse did not always administer the correct insulin doses during the month of September 2022.

Clinician On-Site Inspection

During the on-site inspection, our clinicians toured various medical clinics and interviewed the LVNs. OIG clinicians spoke to the medication nurses and found they were knowledgeable about the medication administration process. The medication areas appeared spacious, clean, and well organized. The nurses reported patients in clinic 3B were administered their medications in the housing unit due to plans to build a medication room in the clinical space.

Our clinicians inquired about the medication alert process when patients received sliding scale insulin doses other than what was ordered. Nursing leadership reported, when nurses manually enter the medication dose for insulin, EHRS will not generate a notification alert. This on-site finding is consistent with OIG clinicians' review of patients receiving inaccurate sliding-scale insulin dosages, which caused patient safety concerns.

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[43] Deficiencies occurred in cases 2 and 26. A significant deficiency occurred in case 2.

[44] Deficiencies occurred in cases 8, 9, and 13.

[45] Sliding-scale insulin is insulin administered based on a set of parameters using the patient's finger-stick blood sugar levels.

Compliance Testing Results

Medication Practices and Storage Controls

The institution always appropriately secured and stored narcotic medications in all applicable 13 clinic and medication line locations (MIT 7.101, 100%).

COR appropriately secured and stored nonnarcotic medications in six of 14 applicable clinic and medication line locations (MIT 7.102, 42.9%). In eight locations, we observed one or more of the following deficiencies: the medication storage cabinet was found disorganized; medications were stored with medical supplies; the medication room lacked a clearly labeled designated area for medications that were to be returned to the pharmacy; nurses did not maintain unissued medication in its original and labeled packaging; and daily security check treatment cart log entries were incomplete.

None of the staff kept medications protected from physical, chemical, and temperature contamination in 14 of the applicable clinic and medication line locations (MIT 7.103, zero). In all 14 locations, we observed one or more of the following deficiencies: staff did not store several medications within the manufacturers' temperature guidelines; staff either did not consistently record room and refrigerator temperatures or did not maintain a medication temperature log; staff did not keep refrigerated medications within acceptable range for the previous 30 days; staff did not store internal and external medications separately; and the medication refrigerator was unsanitary.

Staff successfully stored valid, unexpired medications in only five of 14 applicable medication line locations (MIT 7.104, 35.7%). In nine locations, nurses did not label multi-use medications as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in two of seven applicable locations (MIT 7.105, 28.6%). In four locations, some nurses neglected to wash or sanitize their hands before preparing and administering medications, before donning gloves, or before each subsequent regloving. In one location, the medication nurse did not change gloves when the integrity of the gloves was compromised.

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

Staff in two of seven applicable medication areas used appropriate administrative controls and protocols when distributing medications to patients (MIT 7.107, 28.6%). In five locations, we observed one or more of the following deficiencies: medication nurses did not always verify the patient's identification prior to administration; medication nurses did not consistently observe patients while they swallowed direct observation therapy medications; and medication nurses did not follow CCHCS care guide when administering Suboxone medication.

Pharmacy Protocols

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

In its main pharmacy, staff did not properly store nonrefrigerated medication. Staff stored food items within the medication preparation area. As a result, COR received a score of zero in this test (MIT 7.109).

The institution did not properly store refrigerated or frozen medications in the pharmacy. The medication refrigerator was unsanitary, and the pharmacy temperature logs were not maintained using the Medication Storage Temperature Log (CDCR 7217) at the time of our inspection. As a result, the institution scored zero in this test (MIT 7.110).

The pharmacist-in-charge (PIC) did not thoroughly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC or designee did not complete the medication area inspection checklists (CDCR 7477) in one location. This resulted in a score of zero for this test (MIT 7.111).

We examined 25 medication error reports. The PIC timely or correctly processed only seven of 25 reports (MIT 7.112, 28.0%). For 11 medication errors, the PIC did not complete the pharmacy error follow-up review within the required time frame. The PIC did not provide pharmacy error follow-up review forms for four medication errors. For the remaining three medication errors, the PIC did not document where the error occurred within the pharmacy process.

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 COR, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Of the 23 applicable patients interviewed, 19 indicated they had access to their rescue medications. One patient did not have his rescue inhaler medication upon transfer to the restricted housing unit and did not notify healthcare staff. One patient was not aware the rescue inhaler medication had expired. One patient had an empty rescue inhaler medication. The remaining patient had a nonfunctional rescue inhaler medication. We promptly notified the CEO of these concerns, and health care management immediately reissued replacement rescue inhalers to the patients (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)	2	19	4	9.5%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	18	7	0	72.0%
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)	4	7	0	36.4%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	16	9	0	64.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006)	5	3	0	62.5%
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)	13	0	2	100%
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)	6	8	1	42.9%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	0	14	1	0
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	5	9	1	35.7%
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)	2	5	8	28.6%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	7	0	8	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	2	5	8	28.6%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	7	18	0	28.0%
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): 41.7%

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)	7	8	10	46.7%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	2	1	2	66.7%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	13	3	0	81.3%
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)	5	11	0	31.3%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	5	8	0	38.5%

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

Recommendations

- Medical and nursing leadership should analyze the challenges in ensuring that chronic care, hospital discharge, and en route patients receive their medications timely and without interruption and should implement remedial leadership as appropriate.

- CCHCS should consider developing and implementing measures, such as a patient safety alert, in the medication administration record (MAR) when nurses administer incorrect insulin dosages.

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 patients out 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* (66.1%)**

COR had a mixed performance in preventive services. Staff performed well in administering TB medications, 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, COR performed poorly in monitoring patients taking prescribed TB medications or offering required immunizations to chronic care patients, and COR sometimes timely transferred patients at the highest risk for coccidioidomycosis. 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)	13	3	0	81.3%
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)	5	11	0	31.3%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	23	2	0	92.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	22	3	0	88.0%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	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)	0	15	10	0
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	7	3	0	70.0%
				Overall percentage (MIT 9): **66.1%**

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

Recommendations

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

- Medical and nursing 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***

The overall nursing care at COR was insufficient. Although nurses delivered good care with emergency services and transfers, nurses needed improvement in other areas. Nurses performed incomplete assessments in the outpatient and specialized medical housing areas. Nurses also frequently did not see symptomatic sick call requests within one business day. Lastly, nursing staff did not always follow the prescriber's orders for the administration of insulin. After taking all factors into consideration, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 227 nursing encounters in 45 cases. Of the nursing encounters we reviewed, 73 occurred in the outpatient setting and 42 were sick call requests. We identified 153 nursing performance deficiencies, 44 of which were significant.[46]

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 to develop appropriate interventions.

[46] Deficiencies occurred in cases 1, 2, 4, 5, 8-10, 13, 15–22, 28, 29, 31-36, and 38-49. Significant deficiencies occurred in cases 2, 8,10, 13, 16–22, 34, 38, 40, 44–46, 48, and 49.

Nurses needed improvement with their assessments and interventions. Our clinicians identified 58 outpatient nursing deficiencies, 24 of which were significant.[47] These deficiencies included instances when nurses did not properly identify or triage symptomatic sick call requests. The following are examples:

- In case 2, the patient submitted a sick call request with a request to see the provider for urinary symptoms. The nurse did not ensure the patient was scheduled for a face-to-face evaluation with the RN within one business day.

- In case 10, the patient submitted a sick call request for lower back pain radiating down the right leg. The nurse did not schedule an appointment with the RN for a face-to-face evaluation. Instead, the nurse documented the patient had a chronic care appointment with the provider in approximately two weeks.

- In case 48, the patient submitted a sick call request for neck and shoulder pain as well as a groin rash. The RN saw the patient one day late. Also, the RN did not perform a joint assessment of the shoulder or assess the groin rash.

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. Nurses frequently documented their assessment findings and interventions. Our clinicians identified 10 documentation deficiencies.

Wound Care

Our clinicians reviewed four cases in which nurses provided wound care and identified deficiencies involving peripherally inserted central catheter (PICC) line care.[48] Two examples follow:

- In cases 8 and 19, nurses did not flush PICC lines prior to administration of IV antibiotics.

- In case 20, the patient returned to COR after hospital admission for a left extremity skin infection. Prior to the patient's return to COR, the UM nurse documented a plan of care to include daily dressing changes and use of a front wheel walker for ambulation. Upon the patient's return from the hospital, the nurse did not assess the patient's lower left leg, dressing site, or gait, and did not initiate wound care orders.

[47] Outpatient nursing deficiencies occurred in cases 1, 2, 8, 10, 13, 16-18, 20, 21, 32-36, and 38-49. Significant deficiencies occurred in cases 2, 8, 10, 13, 16-18, 20, 21, 34, 38, 40, 44-46, 48, and 49.

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

Emergency Services

We reviewed 27 urgent or emergent events. Nurses responded promptly to emergent events. However, we identified deficiencies in their assessments, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 24 events involving patient returns from off-site hospitals or emergency rooms. We identified 23 deficiencies, eight of which were significant.[49] However, nurses often performed incomplete assessments when patients returned from the hospital or emergency room, which we detailed further in the **Transfers** indicator.

Transfers

We reviewed seven cases involving transfer-in and transfer-out processes. We found nurses performed good assessments for the transfer-in process and satisfactory assessments for the transfer-out process. Our clinicians identified two minor deficiencies with documentation. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed six cases with a total of 65 nursing events. Our clinicians found nurses often did not perform detailed assessments or intervene appropriately. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed five cases with 21 events, involving nursing care for patients after their return from off-site specialty appointments or procedures. We found nurses frequently performed thorough assessments. However, we found opportunities for improvement in the process when patients refused appointments. Below are some examples:

- In cases 15, 18, and 19, the patients refused off-site specialty appointments. However, the nurse either did not educate patients on the risks and benefits of the specialty appointments or did not obtain signed refusals.

- In case 18, the patient was scheduled for a cystoscopy procedure. However, staff obtained a signed refusal from the patient and two witnesses for an EGD, which is a different procedure.[50]

[49] Deficiencies occurred in cases 1, 8, 19, 20, and 22. Significant deficiencies occurred in cases 8, 20, and 22.

[50] An EGD is an esophagogastroduodenoscopy. In this procedure, the specialist uses a camera to examine the esophagus and the stomach. A cystoscopy is a procedure in which the specialist uses a tube with a camera to examine the bladder and urinary tract.

Medication Management

OIG clinicians examined 112 events involving medication management and found nursing staff did not always follow the prescriber's orders for the administration of insulin. This is discussed further in the **Medication Management** indicator.

Legibility

Most provider and nursing progress notes were electronically entered into patients' electronic health records. However, sick call forms were scanned into the electronic health record. Nurses reviewed these forms and signed them. OIG clinicians identified five deficiencies related to an illegible name or signature of a nurse.[51]

Clinician On-Site Inspection

At the on-site inspection, our clinicians toured the facilities and interviewed staff and supervisors. Our clinicians attended well organized huddles and toured TTA, R&R, medical clinics, specialty clinics, and select medication administration areas. Nursing leadership and clinic SRNIIs reported the Quality Management committee selected random patient sick call samples for the SRNIIs to audit. The SRNIIs did not audit staff in their areas of supervision.

We were informed the chief nursing executive (CNE) and both SRNIIIs had been serving in out-of-class roles. We discussed the weekend sick call triage process with nursing leadership and staff. Nursing leadership stated TTA nursing staff triaged all sick call requests. If a patient complained of an urgent symptom, the LVNs and PTs would obtain information for urgent symptoms and report findings to the TTA RN. The TTA RN would determine if the patient required evaluation the same day or the next business day. For weekend triage of symptomatic sick call requests, some nursing staff reported that patients with symptoms are assessed the next business day. Other nurses stated patients are often seen on the second business day. Nursing leadership mentioned, at the end of a weekend or holiday, the SRN would collect all sick call requests from the TTA and deliver them to the designated clinic RN by the beginning of the next business day. The office technician would then schedule the sick call requests on the following business day, usually a Tuesday.

Nursing leadership also reported a high turnover vacancy rate for nursing staff. Nurses mentioned morale was low.

[51] Deficiencies occurred in case 10, 39, 41, 44, and 49.

Recommendations

- Nursing leadership should determine the root cause(s) of challenges that prevent nurses from performing complete assessments and should implement remedial measures, including training staff, as appropriate.

- Nursing leadership should determine the challenges with scheduling symptomatic patient sick call requests for face-to-face evaluations to occur by the next business day after nurse review 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
Adequate	***Not Applicable***

COR providers generally delivered good care. They made appropriate assessments and decisions, managed chronic medical conditions effectively, and reviewed medical records thoroughly. However, the providers did not always address specialists' recommendations. Taking all aspects into consideration, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 127 medical provider encounters and identified 25 deficiencies, eight of which were significant.[52] OIG physicians also rated the overall adequacy of care for each of the 20 comprehensive case reviews. Of these 20 cases, 15 were ***adequate*** and five were ***inadequate***.

Outpatient Assessment and Decision-Making

Providers generally made appropriate assessments and sound medical plans for their patients. They diagnosed medical conditions correctly, ordered appropriate tests, and coordinated effective treatment plans for their patients. Our clinicians did not identify any significant deficiencies.

Outpatient Review of Records

Providers performed well in reviewing the MAR and renewing their patients' medications timely. For patients returning from hospitalizations, providers performed satisfactorily in reviewing medical records and addressing the hospitalists' recommendations. We identified one deficiency related to the lapse in addressing a recommendation.

[52] Deficiencies occurred in cases 1, 2, 8, 10–14, 17, 19, 21–25, and 36. Significant deficiencies occurred in cases 10, 11, 14, 22, 23, and 25.

- In case 1, the patient returned from the hospital with the diagnosis of inguinal hernia, and the hospitalist recommended to follow-up with general surgery in one week.[53] However, the provider did not address the recommendation.

Emergency Care

Providers generally made appropriate triage decisions and treatment plans when the patients arrived at the TTA. In addition, providers always documented the required progress notes for the TTA events. OIG clinicians identified three deficiencies related to poor provider performance, one of which was considered significant.[54] The significant deficiency is described below:

- In case 22, a patient who was on seizure medications had a seizure and passed out. The TTA nurse notified a provider; however, the provider did not monitor the patient for neurological changes or obtain the seizure medication blood level.

Chronic Care

Providers performed well in managing chronic medical conditions such as hypertension, asthma, hepatitis C infection, and cardiovascular disease. For patients with diabetes, the providers regularly monitored the patients' blood glucose levels and adjusted diabetic medications. However, we identified four deficiencies related to diabetic care.[55] Examples are described below:

- In case 1, the patient had poorly controlled diabetes as evidenced with elevated finger stick blood glucose levels and an elevated hemoglobin A1c; however, the provider did not adjust the patient's insulin or order patient follow-up sooner than 240 days.[56]

- In case 14, a provider ordered an increased dose of morning long-acting insulin; however, the patient had already received his morning long-acting insulin. Subsequently, the patient received two morning doses of long-acting insulin, placing the patient at risk of hypoglycemia.

Specialty Services

Providers appropriately referred and reviewed specialty reports in a timely manner. However, providers did not always address the specialists' recommendations. OIG clinicians identified the following four significant deficiencies:

- In case 10, the cardiologist evaluated the patient for multiple heart conditions, including heart failure and abnormal heart rhythm, and

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[53] An inguinal hernia is a protrusion of the abdominal cavity in the groin area due to a defect or opening on the abdominal wall.

[54] Deficiencies occurred in cases 19, 21, and 22. A significant deficiency occurred in case 22.

[55] Deficiencies occurred in cases 1, 11, 12, and 14.

[56] Hemoglobin A1c is a blood test which measures the average plasma glucose over the previous 12 weeks. According to the CCHCS Diabetic Care guide, the follow-up should be less than seven days.

recommended a patient follow-up appointment in four months. However, the provider did not address the recommendation.

- In case 22, the patient was anemic with positive fecal occult blood test suggestive for possible gastrointestinal bleed, and the gastroenterologist recommended to repeat colonoscopy due to poor bowel preparation.[57] However, the provider did not address the recommendation.

- In case 23, the patient had prostate cancer, and the oncologist recommended genetic testing; however, the provider did not address the recommendation.

- In case 25, the cardiologist evaluated the patient for hypertension and abnormal heart rhythm and recommended the patient follow-up in four months. However, the provider did not address the recommendation.

Outpatient Documentation Quality

Providers generally documented outpatient encounters on the same day. We did not identify any deficiencies related to outpatient documentation quality.

Patient Notification Letters

Providers performed poorly in relaying diagnostic test results to their patients with letters. Providers often did not send complete patient test result notification letters. These deficiencies are discussed in the **Diagnostic Services** indicator.

Clinician On-Site Inspection

At the on-site inspection, our clinicians interviewed COR medical leadership and providers. Medical leadership reported having 11 full-time providers and one and a half vacancies. The providers were enthusiastic about their work and generally satisfied with nursing, diagnostic, and specialty services. The provider meeting occurred every other Tuesday. In this meeting, the providers discussed new policies, obtained medical education, and strategized solutions to address the provider appointment backlog.

We attended two clinic morning huddles. The patient care teams discussed specialty appointments with recommendations, patient glucose logs, hospital returns, and medication refusals. The nurses informed the providers of the scheduled clinic appointments, expiring medications, and new arrivals from other institutions.

Health population management meetings occurred every two weeks for the six main clinics. During our on-site inspection, COR did not have a scheduled health population management meeting.

[57] A fecal occult blood test is used to test for blood in the stool. This test is used to screen for colorectal cancer or other conditions that can cause bleeding in the gastrointestinal tract.

Recommendations

The OIG offers no recommendations for this indicator.

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, COR's specialized medical housing consisted of a correctional treatment center (CTC) and an outpatient housing unit (OHU).

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Inadequate* (59.6%)**

Overall, case review found COR's performance in this indicator needed improvement. COR providers generally delivered good care; however, nurses delivered poor care in the CTC and the OHU. Furthermore, nurses often did not perform thorough admission assessments and reassessments, did not establish appropriate nursing care plans, and did not intervene appropriately when patients had abnormal findings or changes in condition. Taking all factors into consideration, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed mixed performance in this indicator. Although staff often timely completed admission assessments and history with physical examinations, staff needed improvement in medication administration. Factoring all areas of compliance testing, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 60 provider events and 65 nursing events in six cases. 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 77 deficiencies, 15 of which were significant.[58]

Provider Performance

Providers generally delivered good care. Compliance testing showed providers always performed admission history and physical examinations timely (MIT 13.002, 100%).

[58] Deficiencies occurred in cases 8, 9, 19, 22, 24, and 25. Significant deficiencies occurred in cases 8, 19, 22, and 25.

However, our clinical team identified an example in which one provider did not complete a discharge summary.[59]

The providers mostly rounded on their patients at clinically appropriate intervals, reviewed off-site medical records timely, and often made appropriate medical decisions. Case reviewer clinicians identified 11 deficiencies, three of which were significant.[60] Two of these deficiencies related to lapses in addressing specialist's recommendations and are discussed in the **Provider Performance** indicator. One of the significant deficiencies related to poor clinical decision is described below:

- In case 19, the patient with an inguinal hernia had scrotal swelling. The nurse notified a provider; however, the provider did not see the patient until six days later.

Nursing Performance

Our case review clinicians reviewed specialized medical housing encounters related to inpatient nursing care, nursing urgent or emergent care, and nursing care of patients returning from off-site hospitalizations or emergency room transfers.[61] Our clinicians identified 60 deficiencies, 12 of which were significant deficiencies.[62]

Compliance testing showed staff often completed timely patient initial health assessments in the CTC and OHU (MIT 13.001, 84.6%). In four cases, our clinicians reviewed six CTC admissions and one OHU admission.[63] Although nursing admission assessments occurred timely, we identified a pattern of frequently incomplete hospital return assessments as well as admission assessments.[64] Examples of incomplete admission assessments are described below:

- In case 8, a nurse performed a CTC admission for a patient who was discharged from a community hospital for encephalopathy and metabolic acidosis.[65] The patient had multiple chronic conditions including diabetes. The patient had a PICC line previously inserted, but the nurse did not thoroughly assess the catheter site and did not measure the external catheter length.

- In case 19, the patient was readmitted to the OHU after hospitalization for generalized weakness. On admission, the patient complained of constipation and did not have a bowel movement for at least four days. The nurse did not listen to bowel sounds or describe the appearance of the patient's abdomen. In addition, the patient returned with a wound dressing to the tailbone. The

[59] A deficiency occurred in case 19.

[60] Deficiencies occurred in cases 19, 22, 24, and 25. Significant deficiencies occurred in cases 19, 22, and 25.

[61] Transfers to a higher level of care from CTC occurred in cases 8, 9, 19, 22, and 25.

[62] Deficiencies occurred in cases 8, 9, 19, and 22. Significant deficiencies occurred in cases 8, 19, and 22.

[63] Cases 8, 9,19, and 25 had specialized housing admissions.

[64] Deficiencies occurred in cases 8, 9, and 19.

[65] Encephalopathy is a disorder that affects the brain and may cause an altered mental state. Metabolic acidosis is a condition in which acid accumulation in the body can affect the kidneys, diabetes, and normal body functions.

nurse did not assess the wound care dressing site or perform a thorough abdominal assessment for complaints of constipation.

When patients returned from hospitalizations or emergency room evaluations, the nurses did not thoroughly assess the patients. Below are two examples:

- In case 8, the patient was readmitted to the CTC after a hospitalization for a newly diagnosed cancerous throat mass, acute chronic kidney disease, and anemia. The patient returned with a Port-a-Cath inserted into the right upper chest.[66] The nurse did not listen to breath sounds, bowel sounds, or assess for swelling to establish a baseline of the patient's condition.

- In case 22, the patient was readmitted to the OHU after an emergency room evaluation for swelling to both legs. The nurse did not weigh the patient to determine the weight increase related to fluid accumulation. On a subsequent date, the patient was readmitted to the OHU after a hospitalization for acute congestive heart failure. The nurse did not listen to lung sounds, assess for capillary refill or swelling, and did not inquire whether the patient had a prescribed rescue inhaler in his possession.

Establishing a patient care plan helps ensure coordinated care to focus on the patient's health needs. Our clinicians found, in both the CTC and the OHU, nurses often did not initiate patient care plans or, when initiated, plans were incomplete and did not address the essential needs of the patients.[67] The following is an example:

- In case 9, the patient with a history of lung cancer and lung clots had diminished lung sounds and was at a risk for aspiration; however, the nurse did not initiate care plans to proactively address the patient's medical needs.

Assessments, Interventions and Documentation

In both the CTC and OHU, nurses intermittently assessed their patients thoroughly. In addition, when nurses identified abnormal findings, they sometimes did not reassess their patients, provide needed interventions, or ensure sufficient monitoring. The following are examples:

- In case 8, the patient gained eight pounds over a few days, but the nurses did not notify a provider. Later that same day, the nurse found the patient's blood sugar result was low but did not perform a sufficient assessment. That night, the patient's oxygen saturation rate dropped to a critically low level, and the patient was transferred to a community hospital.

- In case 19, the patient with multiple chronic health conditions was housed in both the OHU and CTC. During our review period, the patient had falls, but the nurses did not initiate a plan of care to prevent future falls and did not perform sufficient musculoskeletal assessments. In addition, when the

[66] A port-a-cath is a device that is placed under the skin in the right side of the chest and is attached to a catheter. Medical personnel use this device to give intravenous fluids, chemotherapy, blood and drugs.

[67] Deficiencies occurred in cases 8, 9, 19, and 22.

patient's oxygen saturation was low, the nurses did not perform thorough respiratory and cardiac assessments.

- In cases 19 and 22, nursing staff documented the patients abnormal vital sign results but did not recheck vital signs or notify a provider of their findings.

- In case 22, nurses administered breathing treatments for a patient; however, after the treatments they did not reassess the patient's lungs to check for clinical improvement.

Emergency Care in the Specialized Medical Housing

Our clinicians reviewed 10 events in four cases when patients received urgent or emergent medical care and were transferred to a higher level of care for further evaluation.[68] We describe deficiencies in urgent and emergent care in the following examples:

- In case 8, the CTC RN assessed the patient who complained of abdominal pain, a distended abdomen, and vomiting. The patient had pale, clammy skin. The nurse did not take a complete set of vital signs including temperature, respiratory rate, and oxygen saturation rate. Moreover, the nurse delayed performing an abdominal assessment for 25 minutes, at which time the nurse contacted the on-call provider and received verbal orders to transfer the patient emergently to a higher level of care.

- Also in case 8, the CTC RN assessed the patient who had lung cancer. The patient was lethargic with abnormally low blood pressure. The nurse contacted the provider with a plan to evaluate the patient. However, the RN did not ensure the patient was monitored closely for a change in condition including repeating vital signs and monitoring the patient at regular intervals. The patient's blood pressure was not reassessed until three hours later. Eventually, the patient was transferred to higher level of care after the provider evaluation.

- In case 19, the CTC RN evaluated the patient who had a critically low oxygen saturation rate and an elevated heart rate. The nurse did not identify that the patient was showing signs of respiratory distress. During the evaluation, the RN increased the patient's oxygen rate from two liters to four liters; however, the nurse did not listen to the patient's lung sounds or immediately contact the provider. Approximately 1.5 hours later, the nurse rechecked the patient and found the oxygen saturation rate was still critically low. The nurse switched the patient to a nonrebreather mask, which delivers more oxygen, and after 25 minutes, notified the provider. In addition, the nurse did not administer the recommended oxygen rate for the use of a nonrebreather oxygen mask.

[68] Transfers to higher level of care from CTC occurred in cases 8, 9, 19, 22, and 25.

Medication Administration

Compliance testing showed newly admitted patients to CTC only occasionally received their medications within required time frames (MIT 13.003, 38.5%). However, our clinicians did not identify medication deficiencies at the time of the patients' admissions.

Clinician On-Site Inspection

During the on-site inspection, our clinicians toured the CTC and interviewed staff. COR's CTC had 26 medical beds and was staffed with a designated provider, RNs, LVNs, and CNAs. The CTC has a shift lead RN, who receives hand off communication for shift changes, prepares information for huddles, and performs patient rounds with the provider. The shift lead RN communicated information learned on rounds to the patient's assigned nurse. COR assigns CNA registry staff for patients who are at a high fall risk. CTC staff reported patients in the CTC had all medications prescribed as nurse administered medication, including creams and rescue inhalers.

Our clinicians also toured the COR's OHU and attended the morning huddle. The OHU had 18 medical beds and was staffed with one RN on morning shift. During each swing shift and each night shift, the OHU was staffed with an LVN and a CNA. The morning huddle was well-organized and well-attended by the patient care team, whose members were knowledgeable about their patients.

OHU nurses reported the RN performed patient rounds hourly during the morning shift. In the OHU, the nurses documented rounds with charting by exception. The nurses reported care plans were initiated for CTC patients.

Compliance Testing Results

Compliance On-Site Inspection and Discussion

At the time of the on-site inspection, three of the four specialized medical housing units maintained an operational call light system (MIT 13.101, 75.0%). The CTC had a nonfunctional call light system, and the CTC patients' safety check log had several missing entries (MIT 13.102, zero).

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)	11	2	0	84.6%
Was a written history and physical examination completed within the required time frame? (13.002)	13	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)	5	8	0	38.5%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	3	1	0	75.0%
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	3	0
				Overall percentage (MIT 13): **59.6%**

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

Recommendations

- Nursing leadership should determine the root cause(s) of challenges that prevent nurses from completing thorough assessments and intervening appropriately when a change occurs in the patient's condition and should implement remedial measures as appropriate.

- Nursing leadership should determine the challenges in ensuring nurses initiate and document care plans in EHRS and should implement remedial measures as appropriate.

- Medical, nursing, and pharmacy leadership should consider determining and evaluating causative factors related to the untimely provisions of medications 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
Adequate	***Inadequate* (70.8%)**

Case reviewers found COR performed well in specialty services. COR providers generated appropriate referrals, and staff timely scheduled provider follow-up appointments after specialty services. Nursing performance for specialty care was also good. Access to specialists was sufficient; however, retrieval of specialty reports needed improvement. Taking all factors into consideration, OIG rated the case review component of this indicator ***adequate***.

As in Cycle 6, compliance testing showed COR overall performed poorly in specialty services in Cycle 7. Providers generated appropriate referrals, and staff timely scheduled follow-up appointments. However, access to specialists ranged from excellent to poor, depending on the appointment priority. Preapproved specialty referrals for newly arrived patients occasionally occurred within the recommended time frames. In addition, retrieval of specialty reports and prompt provider endorsements both needed improvement. Taking these factors into consideration, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 86 events related to specialty services, including 49 specialty consultations and 10 procedures. We found 26 deficiencies in this category, nine of which were significant.[69]

Access to Specialty Services

COR's access to specialists for initial appointments varied. Compliance testing showed poor access for high-priority appointments (MIT 14.001, 46.7%), but excellent access for medium-priority appointments (MIT 14.004, 93.3%) and routine-priority appointments (MIT 14.007, 93.3%). Similarly, our case reviewers identified only one minor deficiency related to obtaining an appointment in a specialty department.[70]

[69] Deficiencies occurred in cases 2, 8, 10 ,11, 13, 15, 17–19, and 22–24. Significant deficiencies occurred in cases 8, 10, and 22–24.

[70] This deficiency occurred in case 24.

Compliance testing showed mixed results for follow-up specialty appointments: excellent access for medium-priority appointments (MIT 14.006, 100%), good access for high-priority appointments (MIT 14.003, 85.7%), but poor access for routine-priority appointments (MIT 14.009, 33.3%).

Continuity of care for recent transfers to COR was also poor, as compliance testing showed patients with preapproved specialty requests were only sporadically seen within the required time frames (MIT 14.010, 40.0%).

Provider Performance

Providers referred patients to specialists appropriately and addressed their recommendations with few deficiencies. These deficiencies are discussed in the **Provider Performance** indicator. However, follow-up appointments with providers were inconsistently completed within the recommended time frames (MIT 1.008, 74.4%)

Providers delivered exceptional on-site specialty care for substance use disorders. We did not find any deficiencies associated with this care.

Nursing Performance

Overall, nursing performance for specialty care was good. TTA nurses assessed patients appropriately after return from specialty appointments. TTA and telemedicine nurses were generally documented accurately and ordered provider follow-up appointments within the recommended time frames. Our clinicians found eight deficiencies but did not identify any patterns.[71]

Health Information Management

Staff continued to have problems retrieving specialty documents, similar to Cycle 6. Compliance testing showed this needed improvement (MIT 4.002, 76.7%). Our clinicians found five examples of missing or late reports, four of which were significant.[72] Specific clinical cases are detailed in the **Health Information Management** indicator.

Additionally, compliance testing showed staff often retrieved reports late, or providers often endorsed specialty reports late for high-priority appointments (MIT 14.002, 66.7%), medium-priority appointments (MIT 14.005, 60.0%), and routine-priority appointments (MIT 14.008, 66.7%). Case reviewers identified three deficiencies related to delayed endorsement of a specialist's report.[73] These deficiencies are discussed in the **Health Information Management** indicator.

Staff also did not obtain a proper refusal for a specialty service on several occasions.[74] Although the associated deficiencies were minor, this type of pattern can place patients at risk for suboptimal care and delayed treatment.

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[71] Deficiencies occurred in cases 15, 18, 19, and 22.

[72] Deficiencies occurred in cases 10, 22, and 24. Significant deficiencies occurred in cases 22 and 24.

[73] Deficiencies occurred in cases 8 and 13.

[74] Deficiencies occurred in cases 2 and 17.

Patient Care Team

The case review clinicians identified two significant deficiencies with the patient care team. These deficiencies draw attention to a system or process, often involving multiple participants, and shed light on an unsafe or problematic practice within the institution. The following are the two examples:

- In case 24, an ophthalmologist evaluated the patient for a preoperative cataract surgery appointment. The specialist recommended three eye drops, each with its own dosing schedule and timeline. However, the nurse ordered the specialist's recommended eye drops incorrectly, and the provider signed the incorrect orders, without reviewing the specialist's recommendations. As a result, the patient received multiple doses of incorrect eye drops.

- Also in case 24, a neurosurgeon evaluated the patient as an outpatient and requested a follow-up appointment. Staff ordered the appointment. However, approximately three weeks later, a nurse messaged the patient's provider incorrectly stating a new request for service (RFS) to neurosurgery was required because the patient had never seen a neurosurgeon.[75] The provider generated the new RFS without reviewing the chart or discussing with the nurse. This caused a six-week delay in the patient's follow-up neurosurgery appointment.

Clinician On-Site Inspection

We discussed specialty referral management issues with COR medical leadership, nursing leadership, specialty nurses, and UM nurses. Specialty nurses reported they utilized a tracking tool for retrieving specialty documents. They also stated they had a good rapport with the local specialists and could often arrange an urgent RFS if necessary. In addition, nursing leadership explained COR's unique expectations for the specialty refusal process. Specifically, under COR's expectations, custody would immediately escort patients refusing a specialty service to the medical clinic to meet with the LVN case manager. The LVN case manager would offer the patient education and message the COR provider to address the refusal as appropriate. The LVN case manager would also contact the specialist's office and inform them of the refusal.

[75] A request for service (RFS) is a referral order for a specialty consultation.

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)	7	8	0	46.7%
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)	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)	6	1	8	85.7%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	14	1	0	93.3%
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)	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	12	0	3	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	14	1	0	93.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	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)	2	4	9	33.3%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	8	12	0	40.0%
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)	16	3	1	84.2%
				Overall percentage (MIT 14): **70.8%**

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) *	29	10	6	74.4%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	23	7	15	76.7%

* 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 ascertain causative factors related to the untimely provision or scheduling of patients' specialty service appointments, including those of newly transferred patients with preapproved specialty referrals, and should implement remedial measures as appropriate.

- Medical leadership should ascertain the challenges to the timely receipt and provider review 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* (72.4%)**

COR's performance was mixed in this indicator. COR performed well in committee meetings, grievance responses, initial death report review, and maintaining licensure and certifications. However, the institution performed poorly in other areas. The institution conducted medical emergency response drills with incomplete documentation and required emergency response drill form. Physician managers did not always complete probationary and annual performance 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 ensure newly hired nurses received the required onboarding training. These findings are set forth in the table on the next page. The OIG rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

We reviewed COR's root cause analysis of reported incidents. During our testing period, COR submitted one report to the CCHCS Health Care Incident Review Committee. We found the institution reported the sentinel event late and did not meet reporting requirements per CCHCS policy (MIT 15.001).

We obtained CCHCS mortality reporting data. Ten patient deaths occurred during our review period. For seven mortality reports, the CCHCS nurse and physician consultant-reviewers did not complete the preliminary mortality reports (PMR) within the required time frame. In addition, OIG inspectors found no evidence the regional and institutional

physician and nurse executives received, accepted, or rejected the PMR timely. The remaining three mortality reports were overdue at the time of OIG's inspection (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)	10	2	0	83.3%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	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)	0	3	0	0
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	10	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	6	4	0	60.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	2	7	0	22.2%
Did the providers maintain valid state medical licenses? (15.106)	12	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	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): **72.4%**

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

Recommendations

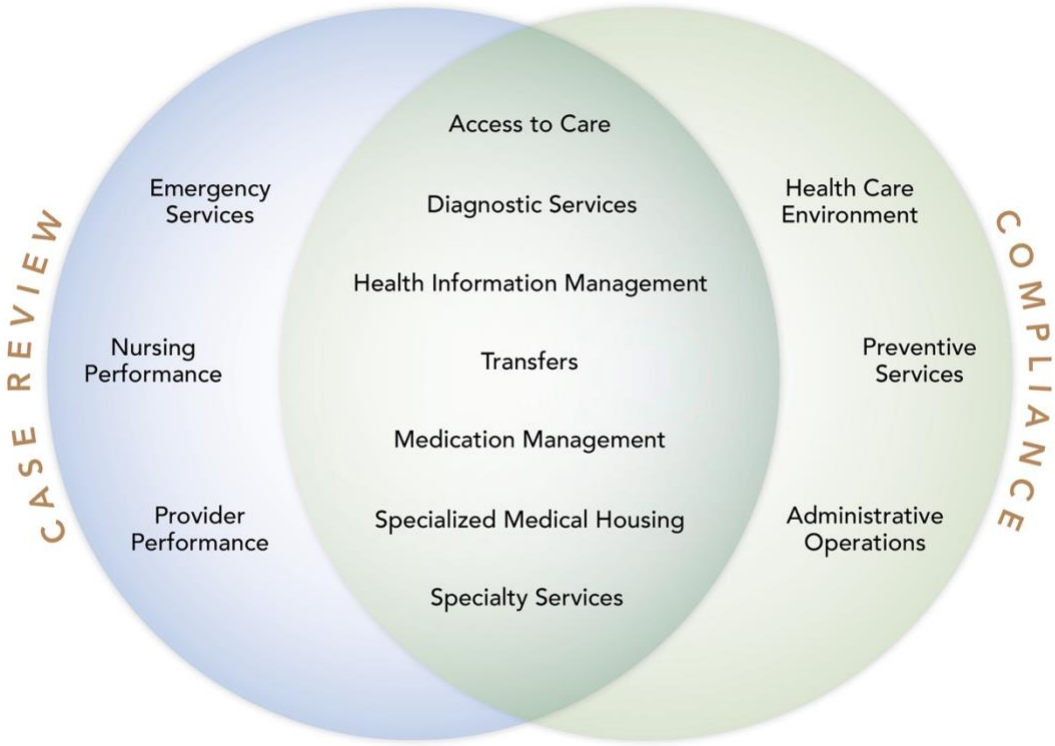
The OIG offers no recommendations for this indicator.

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 COR



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

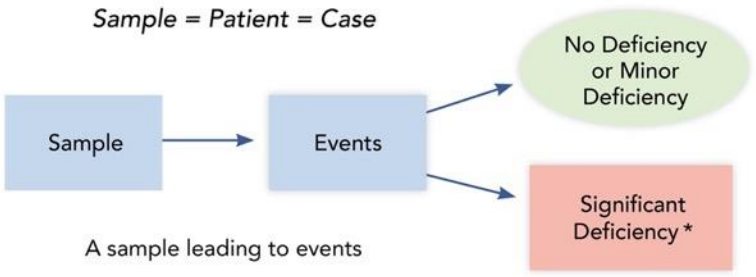
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

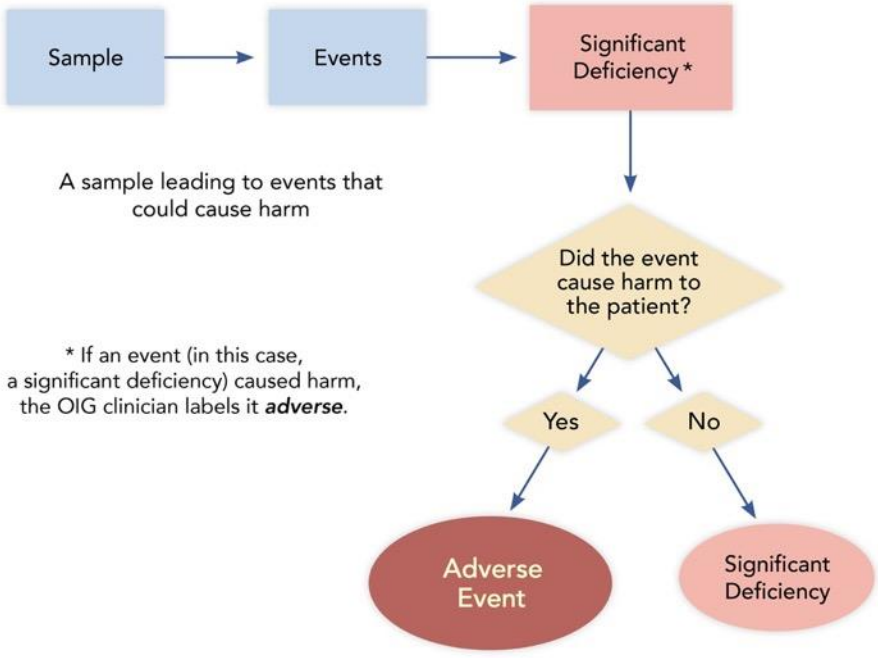
Figure A–2. Case Review Testing

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***.



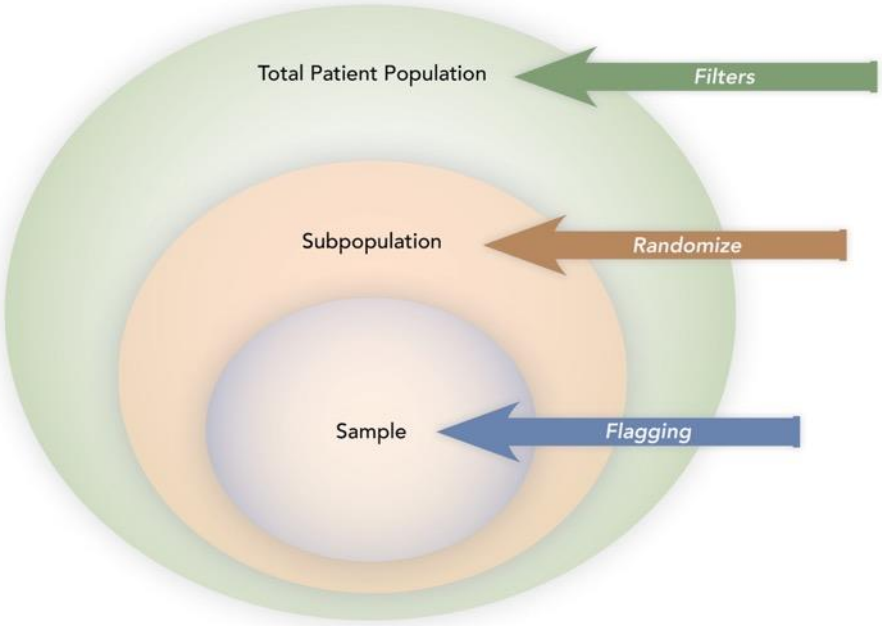
Source: The Office of the Inspector General medical inspection analysis.

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. COR Case Review Sample Sets

Sample Set	Total
Anticoagulation	1
Death Review/Sentinel Events	2
Diabetes	4
Emergency Services – CPR	5
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	18
Specialty Services	3
	49

Table B–220. COR Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Anticoagulation	5
Arthritis/Degenerative Joint Disease	5
Asthma	5
Cancer	3
Cardiovascular Disease	2
Chronic Kidney Disease	3
Chronic Pain	13
Cirrhosis/End-Stage Liver Disease	2
Coccidioidomycosis	1
COPD	4
COVID-19	5
Diabetes	14
Gastroesophageal Reflux Disease	14
Hepatitis C	12
Hyperlipidemia	21
Hypertension	24
Mental Health	26
Migraine Headaches	3
Seizure Disorder	4
Sleep Apnea	6
Substance Abuse	15
Thyroid Disease	4
	193

Table B–2. COR Case Review Events by Program

Diagnosis	Total
Diagnostic Services	229
Emergency Care	53
Hospitalization	46
Intrasystem Transfers In	7
Intrasystem Transfers Out	9
Outpatient Care	263
Specialized Medical Housing	163
Specialty Services	117
	887

Table B–3. COR Case Review Sample Summary

Clinician	Total
MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	11
RN Reviews Focused	27
Total Reviews	58
Total Unique Cases	49
Overlapping Reviews (MD & RN)	9

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Appendix C: Compliance Sampling Methodology

California State Prison, Corcoran

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	40	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	11	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	4	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	40	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	11	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested incarcerated person	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	11	CADDIS off-site admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	15	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	5	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	11	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See **Reception Center**
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	8	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	25	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	23	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	16	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	10	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	13	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	1	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	9	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	12	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
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 • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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July 30, 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 State Prison, Corcoran (COR) conducted by the Office of the Inspector General (OIG) from September 2022 to February 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

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
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region III, CCHCS
Chief Executive Officer, COR
Heather Pool, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Amanda Elhardt, Report Coordinator, OIG

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Cycle 7

Medical Inspection Report

for

California State Prison, Corcoran

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
August 2024

OIG