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Independent Prison Oversight

September 2024

Cycle 7

Medical Inspection Report

California Rehabilitation Center

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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 Rehabilitation Center, the institution had not been delegated back to the department by the receiver.

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

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include emergency cardiopulmonary resuscitation (CPR) reviews in May 2022.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of CRC in June 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between August 2022 and January 2023.

The OIG rated the case review component of the overall health care quality at CRC ***adequate***.

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

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 45 cases, which contained 881 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 June 2023 to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 18 ***adequate*** and two ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 358 patient records and 1,107 data points and used the data to answer 89 policy questions. In addition, we observed CRC's processes during an on-site inspection in April 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 CRC.

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

Table 1. CRC 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

MIT Number	Health Care Indicators	Case Review: Cycle 7	Case Review: Change Since Cycle 6*	Compliance: Cycle 7	Compliance: Cycle 6	Compliance: Change Since Cycle 6*
1	Access to Care	*Proficient*	↑	79.7%	84.0%	=
2	Diagnostic Services	*Adequate*	=	59.8%	63.0%	=
3	Emergency Services	*Adequate*	=	N/A	N/A	N/A
4	Health Information Management	*Adequate*	↓	93.0%	93.0%	=
5	Health Care Environment†	N/A	N/A	56.4%	80.0%	↓
6	Transfers	*Adequate*	=	83.2%	71.0%	↑
7	Medication Management	*Adequate*	=	69.5%	86.0%	↓↓
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	74.6%	69.0%	=
10	Nursing Performance	*Adequate*	=	N/A	N/A	N/A
11	Provider Performance	*Adequate*	=	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	*Adequate*	=	67.5%	83.0%	↓
14	Specialty Services	*Adequate*	=	70.5%	81.0%	↓
15	Administrative Operations†	N/A	N/A	64.2%	71.0%	=

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

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

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

Medical Inspection Results

Deficiencies Identified During Case Review

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

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

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to CRC. Of these 10 indicators, OIG clinicians rated one ***proficient***, nine ***adequate***, and zero ***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, 18 were rated ***adequate*** and two were rated ***inadequate***. In the 881 events reviewed, we identified 179 deficiencies, 16 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 CRC:

- Staff performed well in retrieving and endorsing laboratory diagnostic reports timely.
- Staff performed well in chronic care management of diabetes as the providers and nursing staff collaborated with case management.
- Staff provided good access to providers and nurses for patients.

Our clinicians found the following weaknesses at CRC:

- Nurses did not consistently perform complete and relevant patient assessments during outpatient and emergency care.
- Providers did not always endorse specialty reports timely and did not create the patient notification letters with complete information.
- Staff encountered difficulties in providing continuity of medications when patients were discharged from community hospitals.

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

Compliance Testing Results

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

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

- Staff performed well in scanning, labeling, and entering community hospital discharge reports, specialty service reports, and health care service requests into patients' electronic medical records within required time frames.
- Nurses reviewed health care services request forms and conducted face-to-face encounters within required time frames.
- Providers evaluated patients returning from outside community hospitals within required time frames.

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

- Staff did not consistently provide radiology, routine, and STAT laboratory services within the specified time frames.
- Providers often did not communicate results of diagnostic tests timely. Most patient letters communicating these test results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.
- Staff frequently did not maintain medication continuity for chronic care patients, patients discharged from the hospital, patients admitted to the specialized medical housing unit, and patients who had a temporary layover at CRC.
- Staff did not perform well in ensuring approved specialty services were provided within specified time frames.
- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.
- Nurses did not regularly inspect emergency response bags and treatment carts.

Institution-Specific Metrics

California Rehabilitation Center (CRC), located in the city of Norco in Riverside County, is a medium Level II correctional facility, which houses more than 3,700 inmates. The institution runs multiple clinics in which medical staff handle nonurgent requests for health care services. CRC also treats patients requiring urgent or emergent care in its triage and treatment area (TTA) and houses patients who need assistance with activities of daily living in its outpatient housing unit (OHU). In addition, all patients who arrive at or depart from the institution are screened in the prison's receiving and release (R&R) clinic. CRC has been designated by California Correctional Health Care Services (CCHCS) 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 only limited specialty medical services and consultations for a patient population that is generally healthy. As of July 16, 2024, the department reports on its public tracker that 67 percent of CRC's incarcerated population is fully vaccinated for COVID-19 while 65 percent of CRC's staff is fully vaccinated for COVID-19.[7]

In March 2023, the Health Care Services Master Registry showed that CRC had a total population of 2,992. A breakdown of the medical risk level of the CRC population as determined by the department is set forth in Table 2 below.[8]

Table 2. CRC Master Registry Data as of March 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	36	1.2%
High 2	117	3.9%
Medium	1,375	46.0%
Low	1,464	48.9%
Total	**2,992**	**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 3-24-23.

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

[8] 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, CRC had no vacant executive leadership positions, 2.5 primary care provider vacancies, 0.2 nursing supervisor vacancies, and 6.0 nursing staff vacancies.

Table 3. CRC Health Care Staffing Resources as of March 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	7.5	10.7	78.1	101.3
Filled by Civil Service	5.0	5.0	10.5	72.1	92.6
Vacant	0	2.5	0.2	6.0	8.7
Percentage Filled by Civil Service	100%	66.7%	98.1%	92.3%	91.4%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0.67	0	13.0	13.67
Percentage Filled by Registry	0	8.9%	0	16.6%	13.5%
Total Filled Positions	5.0	5.67	10.5	85.1	106.27
Total Percentage Filled	**100%**	**75.6%**	**98.1%**	**109.0%**	**104.9%**
Appointments in Last 12 Months	1.0	1.0	6.0	15.0	23.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	1.0	0	7.0	8.0
Adjusted Total: Filled Positions	**5.0**	**4.67**	**10.5**	**78.1**	**98.27**
Adjusted Total: Percentage Filled	**100%**	**62.3%**	**98.1%**	**100%**	**97.0%**

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

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

Population-Based Metrics

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

HEDIS Results

We considered CRC'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. CRC'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)— CRC'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. CRC had a 61 percent influenza immunization rate for adults 18 to 64 years old and an 83 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 67 percent.[10]

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. CRC had an 85 percent colorectal cancer screening rate.

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

[10] 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. CRC Results Compared With State HEDIS Scores

HEDIS Measure	CRC Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**6%**	38%	28%	20%
HbA1c Control (< 8.0%) ‡	84%	–	–	–
Blood Pressure Control (< 140/90) ‡	93%	–	–	–
Eye Examinations	89%	–	–	–
Influenza – Adults (18–64)	61%	–	–	–
Influenza – Adults (65+)	83%	–	–	–
Pneumococcal – Adults (65+)	67%	–	–	–
Colorectal Cancer Screening	85%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in April 2023 by reviewing medical records from a sample of CRC'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 CRC population was tested.

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

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

Recommendations

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

Access to Care

- Medical leadership should determine the cause of challenges in timely providing chronic care follow-up appointments, follow-up appointments for transfer-in patients, and follow-up specialty appointments with providers. Leadership should implement remedial measures as appropriate.

Diagnostic Services

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

- Medical leadership should ascertain causes related to the untimely provision of radiology services, the root cause(s) of challenges in reviewing and endorsing radiology reports timely and implement remedial measures as appropriate.

- Medical leadership should determine the root cause of challenges with collecting, receiving, and notifying STAT laboratory results and implement remedial measures as appropriate.

Emergency Services

- Leadership should determine the root cause of challenges for immediate activation of the 9-1-1 system for emergent patients needing a higher level of care and implement remedial measures as appropriate.

- Nursing leadership should determine the root cause of challenges that prevent nurses from performing necessary reassessments as clinically indicated for patients with urgent symptoms in the TTA and implement remedial measures as appropriate.

Health Care Environment

- Medical leadership should determine the root cause for staff not following all required universal hand hygiene precautions and take necessary remedial measures.

- Nursing leadership should determine the root cause for staff not ensuring clinic examination rooms contain essential core medical equipment and verifying that staff follow equipment and medical supply management protocols and take necessary remedial measures.

- Executive leadership should determine the root cause for staff not ensuring clean and sanitary clinics, medical storage rooms, and medication rooms, and take necessary remedial measures.

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

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 implement remedial measures as appropriate.

Preventive Services

- Nursing leadership should determine the challenges in ensuring nursing staff properly document the monitoring of patients taking TB medications and take remedial measures as appropriate.

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

Nursing Performance

- Nursing leadership should determine the root cause of challenges preventing nurses from performing complete assessments and implement remedial measures as appropriate.

Provider Performance

- Medical leadership should analyze the challenges in provider documentation for patient-related calls, emergency phone calls, nurse co-consultations, provider orders, and management plans in the EHRS and implement remedial measures as indicated.

Specialized Medical Housing

- Medical leadership should determine the challenges in providers completing the OHU history and physical examination within the time frame required by CCHCS policy, and implement remedial measures as indicated.

Specialty Services

- Medical leadership should identify the cause of challenges in timely completing follow-up specialty appointments and high-priority

specialty appointments and should continue to implement remedial measures as appropriate.

- Medical leadership should determine the cause of challenges with timely provider review of specialty consultation reports and should implement remedial measures as appropriate.

Access to Care

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Proficient	***Adequate* (79.7%)**

In this cycle, case review found CRC provided excellent access to care, improving from Cycle 6. Staff almost always completed appointments timely, including appointments with clinic providers, nurses, and specialty services. Staff also provided excellent provider access for patients in OHU, and follow-up after hospitalizations, urgent or emergent events, and transferring into CRC. Considering all factors, the OIG rated the case review component of this indicator ***proficient***.

Compliance testing showed CRC performed sufficiently in providing access to care. Staff performed excellently with nurses' reviews of patient sick call requests, completing face-to-face nurse encounters, providing follow-up sick call appointments, and offering provider follow-ups for patients returning from hospitalization. However, CRC scored low for completing chronic care follow-up appointments with providers and provider appointments for patients who transferred into the institution or returned from specialty services. Factoring in all the information, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 157 provider, nursing, TTA, specialty, and hospital events requiring the institution to generate appointments. We identified three deficiencies relating to **Access to Care**, two of which were significant.[11]

Access to Care Providers

Access to clinic providers is an integral part of patient care in health care delivery. CRC did not perform well in providing chronic care follow-up appointments with clinic providers. Compliance testing showed chronic care face-to-face follow-up appointments occurred intermittently (MIT 1.001, 68.0%); however, nurse-to-provider follow-up appointments occurred often (MIT 1.005, 87.5%), and sick call follow-up appointments always occurred timely (MIT 1.006, 100%). Due to movement restrictions related to the COVID-19 pandemic, OIG clinicians considered most cases of provider chart reviews for

[11] Deficiencies occurred in cases 14, 21, and 45. Significant deficiencies occurred in cases 14 and 21.

nonurgent, low-risk, or medium-risk chronic care appointments to be an acceptable alternative to face-to-face or telephonic encounters. OIG clinicians reviewed 69 clinic provider encounters and did not find any deficiencies.

Access to Specialized Medical Housing Providers

CRC had a mixed performance in providing access to OHU providers. Compliance testing showed CRC performed poorly in completing written history and physical examinations of patients admitted to the OHU within the required time frame (MIT 13.002, 30.0%). Our clinicians did not identify any deficiencies regarding patients' access to OHU providers.

Access to Clinic Nurses

CRC performed very well in access to nurse sick calls and provider-to-nurse referrals. Compliance testing showed all nursing sick call requests were reviewed on the same day they were received (MIT 1.003, 100%), and nurses often completed face-to-face visits within one day after the sick call requests were reviewed (MIT 1.004, 90.0%). Our clinicians reviewed 38 nursing sick call requests in 25 cases and identified only two deficiencies related to clinic nurse access.[12] The following is an example:

- In case 15, the nurse consulted with the provider and received orders for the nurse to follow up with the patient within 14 days. However, the nurse did not schedule the follow-up appointment, and as a result, the intended nursing encounter did not occur.

Access to Specialty Services

CRC had a mixed performance in access to specialty services. Compliance testing showed initial high-priority specialty appointments intermittently occurred within the required time frame (MIT 14.001, 73.3%). However, initial medium-priority and routine-priority specialty appointments often occurred timely (MIT 14.004, 80.0%, and MIT 14.007, 93.3%). The institution's more concerning results were with follow-up specialty appointments. Compliance testing showed subsequent high-priority, medium-priority, and routine-priority follow-up specialty appointments sometimes occurred within the required time frame (MIT 14.003, 62.5%, MIT 14.006, 57.1%, and MIT 14.009, 62.5%). Our clinicians assessed 58 specialty service events and identified three deficiencies.[13] The following is an example:

- In case 14, the provider assessed the patient after the patient saw the ophthalmologist, who recommended the patient see the glaucoma specialist within two weeks. However, the patient saw the glaucoma eye specialist more than four weeks late.

We discuss access to specialty services further in the **Specialty Services** indicator.

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[12] Deficiencies occurred in case 15.

[13] Deficiencies occurred in cases 14, 21, and 45, with two significant deficiencies occurring in cases 14 and 21.

Follow-Up After Specialty Services

CRC needed improvement in ensuring patients see their providers within the required time frame after specialty appointments. Compliance testing showed provider appointments after specialty services sometimes occurred within the required time frame (MIT 1.008, 59.3%). OIG clinicians identified one delayed appointment with the provider after specialty services:

- In case 21, the provider ordered a high-priority referral to a lung specialist to evaluate the patient for a lung nodule and abnormal lung findings on X-rays. The provider follow-up appointment occurred after five weeks instead of within five days.

Follow-Up After Hospitalization

CRC performed satisfactorily in ensuring patients see their providers within the required time frames after hospitalizations. Compliance testing showed provider appointments after hospitalization generally occurred within the required time frame (MIT 1.007, 83.3%). The OIG clinicians reviewed 11 hospital returns and did not identify any missed or delayed appointments.

Follow-Up After Urgent or Emergent Care (TTA)

Providers always saw their patients following triage and treatment area (TTA) events as medically indicated. OIG clinicians assessed eight TTA events and did not identify any delayed or missed provider follow-up appointments.

Follow-Up After Transferring Into CRC

CRC had a mixed performance in access to care for patients who have recently transferred into the institution. Compliance testing showed access for intake appointments for newly arrived patients needed improvement (MIT 1.002, 62.5%). OIG clinicians assessed nine transfer-in cases and did not find any deficiencies in this area.

Clinician On-Site Inspection

CRC has five main health care teams: two in the mobile clinic, two in Central Health, and one in Facility D. CRC also has a triage and treatment area (TTA), receiving and release (R&R), specialty clinic, and outpatient housing unit (OHU). In each care team, patients are seen by various health care team members, consisting of a primary care provider (PCP), registered nurse (RN), medical assistant (MA), and case manager (CM).

The OIG clinicians joined the health care team morning huddles and a provider meeting, all of which were well attended. The scheduling supervisor reported scheduling 11 to 13 appointments for each provider per day in addition to co-consults from nursing staff. One part-time provider from the registry supported a health care team and supplemented coverage.

Our case review clinicians spoke with CRC's executive leadership, medical and nursing leadership, and scheduling supervisor regarding the institution's access to care. They reported scheduling of appointments during the review period was impacted by large-

scale COVID-19 quarantines due to the open-dormitory setting, a high volume of new arrivals related to the reception center overflow, and receiving Chuckwalla Valley State Prison transfers. The scheduling supervisor reported the main reason for the previous appointment backlog was related to the large volume of new arrivals and not enough providers to fulfill the appointment needs. The scheduling supervisor mentioned, however, CRC had no current backlog and all appointments previously out of compliance had been scheduled.

Compliance On-Site Inspection and Discussion

Four of six housing units randomly tested at the time of inspection had access to Health Care Services Request Forms (CDCR 7362) (MIT 1.101, 66.7%). In two housing units, custody officers did not have a system in place for restocking the forms. The custody officers reported reliance on medical staff to replenish the 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)	17	8	0	68.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	15	9	1	62.5%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	27	3	0	90.0%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	7	1	22	87.5%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	2	0	28	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	20	4	0	83.3%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	16	11	18	59.3%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	4	2	0	66.7%
Overall percentage (MIT 1): 79.7%				

* 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.

Table 6. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (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)	3	7	0	30.0%
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)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	5	3	7	62.5%
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)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	4	3	8	57.1%
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)	5	3	7	62.5%

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

Recommendations

- Medical leadership should determine the cause of challenges in timely providing chronic care follow-up appointments, follow-up appointments for transfer-in patients, and follow-up specialty appointments with providers. Leadership 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 ***Adequate***	Compliance Rating and Score ***Inadequate* (59.8%)**

Case review found CRC delivered overall good performance in diagnostic services. As in Cycle 6, staff generally completed laboratory testing within appropriate time frames. Staff retrieved and providers endorsed these results timely. However, case review found providers need to improve with communicating with complete patient test result notification letters. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed mixed performance for CRC with diagnostic services. Staff performed excellently in providing routine laboratory services and performed well in reviewing and endorsing laboratory and pathology results. However, staff needed to improve in completing radiology and STAT (immediate) laboratory services, along with provider review and endorsement of radiology results. In addition, providers performed poorly in generating patient letters with all required key elements. On balance, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 390 diagnostic events and found 65 deficiencies, three of which were significant.[14] Of these 65 deficiencies, we found 61 related to health information management (HIM), three related to provider review of results, and one related to the delayed completion of an ordered test.

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

Compliance testing showed CRC needed improvement in completing radiology services within required time frames (MIT 2.001, 60.0%), performed very well in completing laboratory tests (MIT 2.004, 90.0%), and performed poorly in completing STAT laboratory

[14] Deficiencies occurred in cases 2, 4, 6, 7–12, 14–21, and 23. Significant deficiencies occurred in cases 14, 16, and 17.

tests within required time frames (MIT 2.007, 44.4%). OIG clinicians reviewed 22 radiology imaging studies and 367 laboratory tests and found one deficiency in test completion within the required time frame. The following is an example:

- In case 23, the patient arrived at CRC, and the nurse ordered COVID-19 testing to be performed in five days. However, the test was performed one day late.

Clinicians had no STAT laboratory tests in their case review samples.

Health Information Management

CRC staff retrieved laboratory test results promptly and sent them to providers for review. Compliance testing showed providers frequently endorsed laboratory results timely (MIT 2.005, 90.0%). However, CRC needed improvement in providers endorsing radiology test reports (MIT 2.002, 70.0%). Case reviewers also found instances of delayed provider endorsements. The following are two examples:

- In case 14, the patient had a chest X-ray performed. The provider endorsed the results 12 days after the X-ray results were available for review.

- In case 16, the results of a lower back X-ray were available for review. However, the provider endorsed the results two weeks later.

CRC performed poorly in relaying results to patients. Compliance scores for communicating radiology results and laboratory results were poor (MIT 2.003, 20.0% and MIT 2.006, 10.0%). Our clinicians also identified this as an area of underperformance. OIG clinicians identified 61 HIM deficiencies, 60 of which were related to patient test result notification letters. Of these 60 deficiencies, 48 deficiencies were due to missing elements in the letters. The following is an example:

- In case 14, the provider endorsed the laboratory test results and created a patient test result notification letter in EHRS. However, the letter did not include either the date of the test or whether the results are within normal limits.[15]

Compliance testing showed, while CRC staff always retrieved pathology reports timely (MIT 2.010, 100%), and providers always endorsed pathology reports promptly (MIT 2.011, 100%), providers did not notify patients of their pathology results within the required time frame (MIT 2.012, zero).

Clinician On-Site Inspection

At the on-site inspection, the OIG clinicians met with laboratory and radiology staff. CRC provides on-site mobile CT, MRI, and ultrasound imaging services, as well as on-

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

site general X-ray services.[16] The senior radiologic technologist reported CRC imaging services are provided by a part-time and a full-time radiologic technologist. The senior laboratory assistant reported CRC provides clinical laboratory services supported by a regional clinical laboratory specialist using frequent email communications and telephonic support as needed. An external laboratory vendor provides laboratory and pathology diagnostic services for the institution. After the vendor processes the laboratory and pathology specimens, the vendor imports laboratory and pathology results directly to the patients' EHRS for the health care teams to review. The laboratory technician reported any critical laboratory results are communicated through TTA staff directly by the vendor by phone and a fax machine located in the office with 24-hour access by nursing and laboratory staff.

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

Compliance Testing Results

Table 7. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	6	4	0	60.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	7	3	0	70.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	2	8	0	20.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	4	5	0	44.4%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	3	6	0	33.3%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	9	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Overall percentage (MIT 2): 59.8%				

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

Recommendations

- The department should consider developing strategies, such as potentially an electronic solution, to ensure providers generate letters communicating results to their patients, and that the letters include all elements as required by policy.
- Medical leadership should ascertain causes related to the untimely provision of radiology services, the root cause(s) of challenges in reviewing and endorsing radiology reports timely and implement remedial measures as appropriate.
- Medical leadership should determine the root cause of challenges with collecting, receiving, and notifying STAT laboratory results and 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 ***Adequate***	Compliance Rating and Score ***Not Applicable***

CRC generally provided sufficient emergency care. We found nursing staff responded promptly to all emergent events and provided appropriate care. Frequently, nurses performed good initial assessments and documented satisfactorily, which was an improvement from Cycle 6. However, OIG clinicians observed a pattern of incomplete or missing reassessments of patients with initial abnormal clinical presentations or vital signs. Similar to Cycle 6, nursing and medical leadership did not always identify these deficiencies in their clinical reviews. Taking all aspects into consideration, the OIG rated this indicator ***adequate***.

Case Review Results

The OIG clinicians reviewed 29 events, 17 of which were urgent or emergent events. We found 19 deficiencies within various aspects of overall emergency care. Of these 19 deficiencies, four were significant.[17]

Emergency Medical Response

CRC custody and health care staff responded promptly to emergencies throughout the institution. Generally, staff timely activated 9-1-1 emergency medical services. However, the following example showed room for improvement:

- In case 3, staff activated a medical alarm for an unconscious patient but did not contact 9-1-1 until 14 minutes later. This resulted in a delay of transport to a higher level of care.

Cardiopulmonary Resuscitation Quality

In our CPR sample case, custody and medical staff worked collaboratively to provide care, transported the patient to the TTA for additional interventions, and transferred the

[17] Deficiencies occurred in cases 1–3 and 15–17. Significant deficiencies occurred in cases 3, 15, and 17.

patient to a higher level of care. We identified a deficiency with AED documentation and a deficiency with nursing reassessment. The following is an example:

- In case 3, the nurses responded to a medical alarm for an unconscious patient. Staff performed CPR and when the patient had a return of spontaneous circulation, nurses failed to reassess the patient's pulse, respirations, and oxygen saturation.[18]

Provider Performance

Providers performed well in urgent and emergent situations, and after-hours care. Providers were available for consultation with nurses when necessary and were involved in treatment decisions. They made accurate diagnoses and generally completed documentation. However, on two occasions, the providers did not arrange for follow-up appointments with patients when clinically indicated. The following is an example:

- In case 1, the patient had an abnormal electrocardiogram (EKG) and intermittent chest pain but refused to be transported to the community hospital. The provider did not arrange a follow-up appointment to reassess the patient's condition to determine if further intervention was required.

Nursing Performance

Nurses also performed well during emergency events. They responded to emergencies timely and generally provided good initial assessments; however, OIG clinicians identified a pattern of nurses not reassessing initial abnormal patient presentations or vital signs.[19] The following are examples:

- In case 15, the patient requested a blood pressure check because he had swelling in his fingers and toes, throbbing headache, and dizziness. The nurses performed an EKG showing "Acute MI/Ischemia," administered nitroglycerin, and contacted emergency medical services (EMS).[20] However, the nurse did not reassess the patient after each administration of nitroglycerin or obtain vital signs every five minutes until EMS assumed care.

- In case 17, the patient complained of vomiting and had low blood pressure. The nurse administered an anti-nausea medication but did not reassess the low blood pressure.

[18] Return of spontaneous circulation is the resumption of a sustained heart rhythm that perfuses the body after cardiac arrest. Clinically, a health care staff will check and identify a central pulse.

[19] Nursing reassessment deficiencies occurred in cases 2, 3, 15, 16, and 17.

[20] Acute MI/Ischemia means either a heart attack or the heart muscle is not getting enough blood flow. Nitroglycerin is a medication that dilates blood vessels to increase blood flow to the heart.

Nursing Documentation

Nurses in the TTA usually performed thorough documentation for emergent events. However, we identified documentation deficiencies. The following two are examples:

- In case 2, on two occasions, staff activated the medical alarm for a patient for abdominal pain, and the patient was evaluated in the TTA. However, nurses did not document the patient's disposition or actual time of discharge from the TTA.
- In case 3, the nurses did not document AED activity to include whether shock was advised or delivered.

Emergency Medical Response Review Committee

The EMRRC met monthly and discussed emergency responses and unscheduled send outs. However, the EMRRC did not review cases timely and rarely completed the required checklists (MIT 15.003, zero). In addition, while the OIG clinicians found clinical reviews were frequently performed, in four of the nine emergency events, the nursing and medical leadership did not identify opportunities for improvement the OIG clinicians identified.[21] Two examples are listed below:

- In case 2, nursing and medical leadership conducted a clinical review of an emergent event for abdominal pain. They identified the delay in activating 9-1-1. However, they did not identify the nursing staff did not reassess the patient and the nursing staff did not obtain vital signs for 22 minutes while waiting for EMS to arrive.
- In case 15, the clinical review labeled for this patient contained contents for a different patient and event that occurred on the same day.

Clinician On-Site Inspection

During the on-site inspection, we toured the TTA and spoke to nursing staff. The CRC TTA contained two beds in independent bays, providing sufficient space for emergency care. The TTA nurse explained they scheduled two RNs during each shift and assigned a provider for TTA, who also covered the OHU. Nurses reported, if the assigned provider was unavailable when needed, staff would contact the primary care provider. An assigned provider was on call for the TTA after hours.

The TTA RN informed the OIG clinicians the AEDs were capable of recording activity and the activity can be downloaded into the EHRS. Although AED activity can be downloaded, the chief nurse executive (CNE) reported the nurses were also expected to document emergency activity, to include whether a shock was advised or delivered.

The OIG clinicians also interviewed the TTA supervising registered nurse (SRN). The SRN described his role in supporting the TTA RNs during emergencies and dual role as supervisor of the OHU. Additionally, the SRN was designated as the EMRRC

[21] Deficiencies occurred in cases 2, 3, 15, and 16. Significant deficiencies occurred in cases 3 and 15.

Coordinator. The SRN reported an estimated 60 emergency transfers per month. The supervisor reviewed each emergency prior to the end of each shift and addressed findings with the staff in real time. In addition to shift reviews, the SRN reported mock drills and tabletop reviews are conducted quarterly, in conjunction with custody staff.[22] The SRN stated these activities are to assist staff in identifying gaps and practicing skills, as well as to offer additional education and guidance.

[22] A tabletop review is a written emergency case scenario activity involving a team of responders discussing necessary actions in the event of a real emergency.

Recommendations

- Leadership should determine the root cause of challenges for immediate activation of the 9-1-1 system for emergent patients needing a higher level of care and implement remedial measures as appropriate.
- Nursing leadership should determine the root cause of challenges that prevent nurses from performing necessary reassessments as clinically indicated for patients with urgent symptoms in the TTA and implement remedial measures as appropriate.

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 ***Adequate***	Compliance Rating and Score ***Proficient*** **(93.0%)**

Case review found CRC performed well in health information management. Staff performed very well in retrieving and scanning hospital discharge records, specialty reports, and urgent and emergent records. However, case review found opportunities for improvement in providers communicating test results to patients with notification letters. Taking all factors into consideration, the OIG rated the case review component of this indicator ***adequate***.

CRC performed exceptionally well overall in compliance testing. Staff always timely scanned patient sick call requests, along with almost always timely retrieving and scanning hospital records. Staff also performed well in properly scanning and labeling medical records in the correct patient files, scanning specialty reports, and endorsing hospital reports. Taking all results into consideration, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

We reviewed 881 events and found 68 deficiencies related to health information management, four of which were significant.[23]

Hospital Discharge Reports

Compliance testing showed staff performed well in timely retrieving and scanning hospital discharge documents into patients' electronic health records (MIT 4.003, 95.0%). In addition, nearly all the hospital discharge reports contained physician discharge summaries, and providers reviewed these reports timely (MIT 4.005, 91.7%). OIG clinicians reviewed 11 off-site emergency department and hospital encounters and did not identify any deficiencies.

[23] Deficiencies occurred in cases 2, 4, 6–12, and 14–21. Deficiencies occurred in cases 14, 16, 17, and 20.

Specialty Reports

For the most part, CRC performed well in retrieving and reviewing specialty reports. Compliance testing showed most specialty reports were scanned into the electronic health record system within required time frames (MIT 4.002, 86.7%). On the other hand, staff needed improvement in retrieving and reviewing high-priority specialty service consultant reports timely (MIT 14.002, 66.7%). CRC performed poorly in retrieving and reviewing medium-priority and routine-priority specialty service consultation reports timely (MIT 14.005, 46.2% and MIT 14.008, 53.3%). Our clinicians reviewed 54 specialty reports and identified two deficiencies, neither of which was significant.[24] The following is an example:

- In case 14, the provider endorsed the specialist consultation report two days late.

We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

CRC performed variably with diagnostic reports. Compliance testing showed providers almost always endorsed laboratory reports within required time frames (MIT 2.005, 90.0%) but only sometimes endorsed imaging reports within required time frames (MIT 2.002, 70.0%). Staff always received the final pathology study within the required time frames (MIT 2.010, 100%). Providers always reviewed and endorsed pathology reports within required time frames (MIT 2.011, 100%) but never communicated results of the pathology study to patients within required time frames (MIT 2.012, zero). Our clinicians identified 65 deficiencies, three of which were significant.[25] The following is an example:

- In case 14, the patient had a chest X-ray performed. However, the provider endorsed the results 12 days after the results became available.

Most deficiencies (46 out of 65 deficiencies) related to providers communicating test results with incomplete test results letters. The following is an example:

- In case 6, the provider endorsed the laboratory test results and sent a patient notification letter. However, the letter did not include either the date of the test or whether the results were within normal limits.

Compliance testing showed CRC poorly managed the STAT test results. Specifically, either the providers rarely acknowledged the STAT test results timely, or nursing staff did not notify the provider timely (MIT 2.008, 33.3%). Clinical reviewers did not have any STAT laboratory tests in the review samples.

The **Diagnostic Services** indicator provides more details on CRC's diagnostic services performance.

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[24] Deficiencies occurred in cases 12 and 14.

[25] Significant deficiencies occurred in cases 16, 17, and 20.

Urgent and Emergent Records

OIG clinicians reviewed 29 emergency care events, 17 of which were urgent or emergent. Providers recorded their emergency care sufficiently, including off-site telephone encounters. OIG clinicians found four deficiencies in nursing and provider documentation.[26] Nursing deficiencies are discussed further in the **Emergency Services** indicator. The following is an example of a provider documentation deficiency:

- In case 15, a TTA RN consulted the on-call provider for the patient with high blood pressure and symptoms of headache and dizziness. The provider ordered hydration, monitoring, EKG, and transfer to a higher level of care. However, the provider did not document a progress note in the EHRS.

Scanning Performance

Staff performed well with the scanning process. Compliance testing showed staff almost always properly scanned and labeled patients' medical files (MIT 4.004, 91.7%). OIG clinicians identified one deficiency related to scanning medical documents:

- In case 21, the pulmonary specialist consultation report was scanned into EHRS. However, it was mislabeled as "Pulmonary Function Studies."

Clinician On-Site Inspection

Our clinicians discussed health information management processes with the CRC health records technician supervisor, office technicians, and providers. The health records supervisor reported CRC implemented an improvement strategy for retrieval, scanning, and endorsement of health records by tracking all community hospital emergency room encounters, hospital admissions, off-site appointments, and telemedicine specialty appointments and manually reviewing dates of scanning and provider endorsements daily.

[26] Deficiencies occurred in cases 2, 3, and 15.

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	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	26	4	15	86.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	19	1	4	95.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	22	2	0	91.7%
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)	22	2	0	91.7%
				Overall percentage (MIT 4): 93.0%

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

Table 9. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	7	3	0	70.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	3	6	0	33.3%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	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)	6	7	2	46.2%
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)	8	7	0	53.3%

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

Recommendations

The OIG offers no recommendations for this indicator.

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*** **(56.4%)**

In this cycle, multiple aspects of CRC's health care environment needed improvement: clinics' medical supplies storage areas contained expired medical supplies, compromised sterile medical supply packaging, unidentified medical supplies, or medical supplies stored with cleaning materials. In addition, several examination and medication rooms had damaged floors and were unsanitary while emergency medical response bag (EMRB) logs were missing staff verification or inventory was not performed. Moreover, several clinics did not meet the requirements for essential core medical equipment and supplies. Lastly, staff sporadically washed their hands properly before examining patients or before regloving. Taking all results into consideration, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Outdoor Waiting Areas

The institution had no outdoor waiting areas for patients.

Indoor Waiting Areas

We inspected CRC's indoor waiting areas. Health care and custody staff reported the existing indoor waiting areas contained sufficient seating capacity to provide patients protection from inclement weather (see Photo 1). Custody staff also reported they bring in a few patients at a time to prevent overcrowding the indoor waiting areas. During our inspection, we did not observe overcrowding in the clinics' waiting areas.

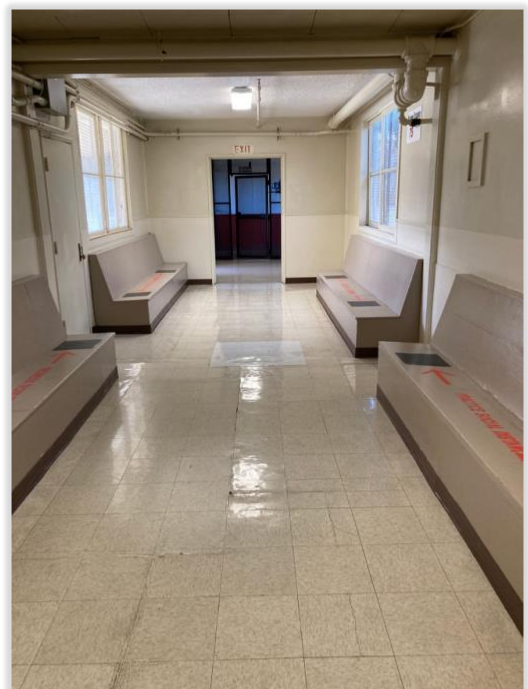

Photo 1. Triage and treatment area waiting room (photographed on 4-10-23).

Clinic Environment

Nine of 10 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, 90.0%). In one clinic, we observed laboratory staff providing services to multiple patients at the same time in the blood draw stations, which hindered auditory privacy.

Six of the eight applicable clinics we observed contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 75.0%). In one clinic, the examination room had unsecured confidential medical records. The remaining clinic examination room lacked visual privacy for conducting clinical examinations.

Clinic Supplies

Five of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 50.0%). We found one or more of the following deficiencies in five clinics: expired medical supplies (see Photo 2), unidentified medical supplies, and cleaning materials stored with medical supplies (see Photo 3).

Photo 2. Expired medical supplies dated December 2022 (photographed on 4-10-23).

Photo 3. Medical supplies stored in the same area as cleaning supplies (photographed on 4-11-23).

Only two of the 10 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 20.0%). The remaining eight clinics lacked medical supplies, contained improperly calibrated equipment, or contained nonfunctional equipment. The missing items included a tongue depressor and a nebulization unit. The staff had not properly calibrated both an oto-ophthalmoscope and an automated vital signs machine. We found a nonfunctional oto-ophthalmoscope. Staff did not properly log the results of the defibrillator or an AED performance test within the last 30 days. In addition, several clinics' daily glucometer quality control logs were inaccurate, incomplete, or not logged within the last 30 days.

We examined EMRBs stored in seven applicable locations to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. None of the EMRBs passed our tests (MIT 5.111, zero). We found one or more of the following deficiencies: staff did not ensure the EMRB's compartments were sealed and intact; staff had not inventoried the EMRBs when the seal tags were replaced; and staff did not always log EMRB daily glucometer quality control results.

Medical Supply Management

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

Infection Control and Sanitation

Staff appropriately, cleaned, sanitized, and disinfected only two of 10 clinics (MIT 5.101, 20.0%). In eight clinics, we found one or more of the following deficiencies: cleaning logs were not maintained; biohazardous waste was not emptied after each clinic day; medical supply cabinet was unsanitary; and several clinic floors were damaged and unsanitary (see Photo 4).

Photo 4. Clinic floor damaged and unsanitary (photographed on 4-10-23).

Staff in six of nine applicable clinics (MIT 5.102, 66.7%) properly sterilized or disinfected medical equipment. In two clinics, we found several instances of previously sterilized medical equipment with compromised packaging. In addition, staff did not routinely log the receipt of used medical equipment requiring sterilization, and staff did not routinely date stamp sterilized medical equipment packaging. In another clinic, staff did not mention disinfecting the exam table as part of their daily start-up protocol.

We found operating sinks and hand hygiene supplies in the examination rooms in eight of 10 clinics (MIT 5.103, 80.0%). In one clinic, the patient restrooms lacked antiseptic soap and disposable hand towels. In another clinic, the patient restroom lacked disposable hand towels.

We observed patient encounters in seven applicable clinics. In five clinics, clinicians did not wash their hands before applying gloves or during subsequent regloving (MIT 5.104, 28.6%).

Health care staff in nine of 10 clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 90.0%). In one clinic, we discovered overfilled biohazard containers and found the designated storage area unsecured.

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order (MIT 5.999).

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)	2	8	1	20.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	6	3	2	66.7%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	2	1	80.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	5	4	28.6%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	1	1	90.0%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	5	5	1	50.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	2	8	1	20.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	1	1	90.0%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	6	2	3	75.0%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	0	7	4	0
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): 56.4%

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

Recommendations

- Medical leadership should determine the root cause for staff not following all required universal hand hygiene precautions and take necessary remedial measures.
- Nursing leadership should determine the root cause for staff not ensuring clinic examination rooms contain essential core medical equipment and verifying that staff follow equipment and medical supply management protocols and take necessary remedial measures.
- Executive leadership should determine the root cause for staff not ensuring clean and sanitary clinics, medical storage rooms, and medication rooms and take necessary remedial measures.
- Nursing leadership should determine the root cause for staff not ensuring the emergency medical response bags (EMRBs) are regularly inventoried and sealed, or staff failing to properly complete the monthly logs, and take necessary remedial measures.

Transfers

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (83.2%)**

Compared with Cycle 6, CRC's transfer process showed similar performance. Although case review found the transfer processes overall were satisfactory, OIG clinicians identified areas for improvement in documenting a five-day supply of medication was provided for patients transferring out. Considering all aspects of transfer-related care and case review, the OIG rated the case review component of this indicator ***adequate***.

Compared with Cycle 6, CRC's overall compliance performance greatly improved for this indicator. CRC still needs to improve in completing initial health screening forms. However, the institution performed excellently in completing the assessment and disposition section of the screening process and in ensuring medication continuity for newly transferred patients. Consequently, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 47 events in 19 cases in which patients transferred into or out of the institution or returned from off-site hospitalizations or emergency room encounters. We identified 17 deficiencies, three of which were significant.[27]

[27] Deficiencies occurred in cases 2, 5, 14–17, 25, 27, and 43–45. Significant deficiencies occurred in cases 15, 16, and 45.

Transfers In

CRC's performance was mixed in the transfer-in process. Compliance testing showed R&R nurses needed improvement in completing the initial health screening form thoroughly (MIT 6.001, 72.0%.) However, the nurses almost always completed the assessment and disposition section of the form (MIT 6.002, 95.8%). Compliance testing also showed staff generally ensured medication continuity occurred at the time of transfer for newly arrived patients (MIT 6.003, 81.8%) but needed improvement in medication continuity for patient layovers at the institution (MIT 7.006, 57.1%). Moreover, compliance testing revealed newly arrived patients were sometimes seen by a provider within necessary time frames (MIT 1.002, 62.5%).

OIG clinicians reviewed 17 events in nine cases in which patients transferred into the facility from other institutions. We identified only two minor deficiencies:[28]

- In case 5, the patient arrived at CRC and was scheduled to receive a KOP blood pressure medication; however, the patient missed the dose.[29]

- In case 45, the nurse performing the initial intake assessment did not obtain or document the patient's weight.

Transfers Out

CRC'S transfer-out process was satisfactory. OIG clinicians reviewed nine transfer-out events, in a total of six cases, of which five events were unscheduled transfers. In these instances, nurses received notice with limited time to prepare for the transfer. The nurses did not always document notification of pending specialty consultations and did not always document transferring the five-day supply of medications. The following are examples:

- In cases 2, 25, and 45, the nurses did not document transferring the five-day supply of medications with the patients.

- In cases 25 and 27, the patients transferred to another facility. However, the nurses did not document notifying the receiving institution of pending specialty consultations.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room encounters are at high risk for lapses in care quality. These patients have typically 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.

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[28] Deficiencies occurred in cases 5 and 45.

[29] KOP means "keep on person" and refers to medications in which a patient can keep and self-administer according to the directions provided.

CRC staff performed sufficiently in the return process for hospitalizations and emergency room encounters. In compliance testing, CRC staff often provided follow-up appointments within required time frames to patients returning from hospitalizations and emergency room encounters (MIT 1.007, 83.3%). However, OIG clinicians identified significant deficiencies in medication continuity, which is addressed further in the **Medication Management** section.

Clinician On-Site Inspection

OIG clinicians toured the R&R area and interviewed the RN on duty. The nurse reported an RN was staffed on each shift, although after business hours, no custody or nursing staff are present in the R&R area. Instead, after hours, the R&R RN reports to the TTA to conduct their duties. The R&R RN reported on Wednesdays they receive the list of incoming and outgoing transfers scheduled for the subsequent week. The nurse estimated, prior to COVID-19, CRC averaged 65 new arrivals per week; however, as of our on-site inspection, the average had increased to a range of 60 to over 100 new arrivals per week. Additionally, the nurse reported an average of 10 to 20 patients transferring out per week, with an increased number of patients paroling compared to the number in the past. The R&R nurse explained a well-organized system for processing transfer patients and shared a task list for other shifts to continue any additional work remaining. Although, the nurse described the custody counterparts as being relatively new, they were building a good working relationship.

While on-site, OIG clinicians also spoke with nursing leadership. Leadership indicated their staff performed weekly audits for hospital returns and used their OIG metrics to ensure nurses provide quality care as it relates to patient transfers. In addition, they reported the daily care team huddles included dedicated time to discuss transfer-related concerns.

Compliance On-site Inspection and Discussion

CRC had no transfer-out patients scheduled the week of the on-site inspection.

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)	18	7	0	72.0%
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)	23	1	1	95.8%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	9	2	14	81.8%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	N/A	N/A	N/A	N/A
Overall percentage (MIT 6): 83.2%				

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)	15	9	1	62.5%
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)	20	4	0	83.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	19	1	4	95.0%
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)	22	2	0	91.7%
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)	12	8	4	60.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	23	2	0	92.0%
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)	4	3	0	57.1%
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)	N/A	N/A	N/A	N/A

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

Recommendations

The OIG offers no recommendations for this indicator.

Medication Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (69.5%)**

Case review found CRC's performance in medication management was satisfactory. Staff performed well with newly prescribed medications and chronic care medication continuity. However, staff did not perform well with the hospital medication reconciliation process. Taking all factors into account, the OIG rated the case review component of this indicator ***adequate***.

CRC had a mixed performance in compliance testing. Staff performed exceptionally well in employing general security and storing medications in its main pharmacy, providing newly prescribed medication orders, and providing medications for patients transferring within the institution. However, staff needed improvement in timely providing chronic care medications, hospital discharge medications, and medications for patients en route who layover at CRC. Considering all testing results, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 117 events in 28 cases related to medications and found 14 medication deficiencies, two of which were significant.[30]

New Medication Prescriptions

Staff performed excellently with timely administration and availability of new prescription medications (MIT 7.002, 96.0%). OIG case review clinicians only found two minor deficiencies related to new prescriptions. The following are examples:

- In cases 1 and 17, the patients received their KOP pain medications one to two days late.

[30] Deficiencies occurred in cases 1, 2, 4, 5, 7–27, and 43–45. Significant deficiencies occurred in cases 16 and 45.

Chronic Medication Continuity

Compliance testing revealed patients rarely received their chronic care medications within required time frames (MIT 7.001, 15.0%). In contrast, OIG case reviewers found CRC performed well with chronic care medications. We identified only two examples in which patients did not receive their medications timely:

- In cases 12 and 13, the patients did not receive their KOP cholesterol medications in the month of January.

Hospital Discharge Medications

In compliance testing, CRC needed improvement in ensuring patients received their medications on return from an off-site hospital or emergency room encounter (MIT 7.003, 60.0%). In four cases, our clinicians also found health care staff inaccurately reconciled the hospital recommended medications, resulting in three medication errors:

- In case 16, the patient returned from a community hospital with medication orders. However, CRC health care staff inaccurately reconciled the prophylactic blood thinning medication order, and the patient received double the amount of the recommended first dose. Fortunately, the next morning, the pharmacist recognized the error and corrected the dosage.

- In case 43, the patient returned from the community hospital after sustaining a bleed in the brain. However, CRC health care staff inaccurately reconciled the hospital medications, resulting in the patient receiving aspirin, a medication that thins the blood, on two consecutive days, although the hospital recommended the medication be discontinued.

- In case 45, the patient returned from the community hospital after knee surgery. However, CRC health care staff inaccurately reconciled the hospital medications, resulting in the patient not receiving prophylactic medications to reduce the risk of blood clots.

Specialized Medical Housing Medications

Staff performed well in ensuring patients received their needed medications during admission in the OHU. OIG clinicians found OHU nurses often administered medications timely. We identified the following deficiency:

- In case 43, the patient did not receive their cholesterol and blood pressure medications for four days.

Transfer Medications

For transfer medications, staff performed well. Compliance testing showed CRC performance was satisfactory with ensuring patients who transferred into the institution received their medications timely (MIT 6.003, 81.8%). The staff also performed very well with medication continuity for patients transferring from yard to yard (MIT 7.005, 92.0%).

However, patients who were on layover and temporarily housed at CRC sometimes received their medications within required time frames (MIT 7.006, 57.1%). OIG clinicians found a deficiency with continuity of KOP medication for a newly arrived patient and three documentation deficiencies related to the amount of medication transferred with patients. These are discussed further in the **Transfers** indicator.

Medication Administration

Compliance testing showed nurses frequently administered tuberculosis (TB) medications within required time frames (MIT 9.001, 92.0%). However, the institution performed poorly with monitoring patients taking TB medications, as required by policy (MIT 9.002, 44.0%). Our clinicians did not have any case review samples with events related to TB medications.

Case review clinicians found nurses often administered medications properly.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians interviewed the pharmacist in charge (PIC) and nurses and toured the medication lines. The PIC reported a recent change to the workflow, which allowed central pharmacy to be contacted 24 hours a day, seven days a week. The Facility B medication line had three medication administration windows. Nurses reported they had previously been staffed with two nurses but received a third nurse when facility A closed. The Facility C medication line had two medication administration windows, staffed with two nurses. Medication line nurses were knowledgeable on the KOP process of documentation, administration, and medication return time frames. Additionally, nurses reported good rapport with custody staff and experienced minimal challenges with patients not reporting to the medication line. One nurse shared a practice of assisting patients with obtaining new identification when their identification was missing or damaged, to ensure they could receive medication timely.

During the well-coordinated nursing huddles, OIG clinicians observed health care staff discussing expired medication orders, medication concerns, and plans for follow-up. After the huddle, our clinicians met with the LVN care coordinators who reported they were responsible for providing education on medication and vaccines related to chronic care diagnoses.

Our clinicians also met with the TTA RN and discussed medication reconciliation for patients returning to CRC from a hospitalization or off-site specialty appointment. The TTA RN described challenges with medication reconciliation in EHRS as the system prefills the wrong dates and defaults to KOP medication versus nurse administered. Moreover, if completed, the order cannot be modified. Instead, the order must be discontinued, and staff must enter a new order. Furthermore, the nurse reported not being able to type in free text in the order entry, and the drop-down selection menu items are limited.

Compliance Testing Results

Medication Practices and Storage Controls

Staff adequately stored and secured narcotic medications in eight of nine clinic and medication line locations (MIT 7.101, 88.9%). In one location, staff did not properly and securely store narcotic medications as required by CCHCS policy.

Staff adequately stored and secured nonnarcotic medications in four of nine clinic and medication line locations (MIT 7.102, 44.4%). In five locations, we observed one or more of the following deficiencies: nurses did not maintain unissued medication in its original labeled packaging; treatment cart log was missing daily security check entries; and the medication area lacked a clearly labeled designated area for refrigerated medications to be returned to the pharmacy.

Staff properly protected medications from physical, chemical, and temperature contamination in only four of the nine clinic and medication line locations (MIT 7.103, 44.4%). In five locations, we found one or more of the following deficiencies: staff did not consistently record the room and refrigerator temperatures; staff did not store internal and external medications separately; and the medication refrigerator was unsanitary.

Staff always adequately stored valid, unexpired medications in all medication line locations (MIT 7.104, 100%).

Nurses did not perform proper hand hygiene and contamination control protocols in all six applicable locations (MIT 7.105, zero). In six locations, some nurses neglected to wash or sanitize their hands before each subsequent re-gloving.

Staff in four of six applicable medication preparation and administration areas intermittently had appropriate administrative controls and protocols (MIT 7.106, 66.7%). In two locations, medication nurses did not describe the process they followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physician's order.

Staff in only one of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to patients (MIT 7.107, 16.7%). In five locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within the required time frame; medication nurses did not always verify patient's identification using a secondary identifier; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; and medication nurses did not follow CCHCS care guide when administering Suboxone medication because the nurses did not provide counseling for 30 seconds to ensure the Suboxone medication adhered to the patient's mouth.

Pharmacy Protocols

Staff followed general security, organization, and cleanliness management protocols for nonrefrigerated and refrigerated medications stored in its pharmacy (MITs 7.108, 7.109, and 7.110, 100%).

The PIC correctly accounted for narcotic medications stored in CRC's pharmacy (MIT 7.111, 100%).

We reviewed eight medication error reports. The PIC timely and correctly processed all reports (MIT 7.112, 100%).

Nonscored Tests

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

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

Compliance Testing Results

Table 13. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	3	17	5	15.0%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	24	1	0	96.0%
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)	12	8	4	60.0%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	23	2	0	92.0%
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)	4	3	0	57.1%
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)	8	1	3	88.9%
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)	4	5	3	44.4%
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)	4	5	3	44.4%
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)	9	0	3	100%
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)	0	6	6	0
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	4	2	6	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	1	5	6	16.7%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	8	0	0	100%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 7): 69.5%			

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

Table 14. Other Tests Related to Specialized Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	9	2	14	81.8%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	N/A	N/A	N/A	N/A
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	23	2	0	92.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	11	14	0	44.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	5	5	0	50.0%

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 implement remedial measures as appropriate.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as being at high risk for coccidioidomycosis (Valley Fever), we tested the institution's performance in transferring 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*** **(74.6%)**

CRC 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, CRC performed poorly in monitoring patients taking prescribed TB medications and in offering required immunizations for chronic care patients. The OIG rated this indicator ***inadequate***.

Compliance Testing Results

Table 15. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	23	2	0	92.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	11	14	0	44.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	24	1	0	96.0%
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)	2	11	12	15.4%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
Overall percentage (MIT 9): 74.6%				

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

Recommendations

- Nursing leadership should determine the challenges in ensuring nursing staff properly document the monitoring of patients taking TB medications and take remedial measures as appropriate.

- Medical leadership should analyze the challenges related to the untimely provision of preventive vaccines to chronic care patients and 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
Adequate	***Not Applicable***

CRC's overall nursing care was sufficient. Compared with Cycle 6, OIG clinicians found more nursing deficiencies in fewer nursing encounters. While the majority of these deficiencies were minor and did not place patients at significant risk of harm, our clinicians identified opportunities for improvement in several areas, such as nursing assessments, as detailed below. Considering all these factors, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 157 nursing encounters in 42 cases. Of the nursing encounters we reviewed, 76 occurred in the outpatient setting, and 38 were nursing sick call requests. We identified 57 overall nursing performance deficiencies, five of which were significant.[31]

Outpatient Nursing Assessment and Interventions

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

Nurses frequently provided timely and appropriate care. OIG clinicians identified 26 outpatient nursing deficiencies, which included a pattern of incomplete clinically

[31] Deficiencies occurred in cases 1–3, 10–17, 22, 25, 27–34, and 41–45. Significant deficiencies occurred in cases 14, 15, 17, and 43.

relevant assessments. Of those, one was considered significant.[32] The following are examples of both the significant deficiencies and deficiency patterns we identified:

- In case 14, the sick call nurse evaluated a patient with swelling around the eyes, as well as redness, tearing, and a sluggish right eye pupil reaction. However, rather than conduct a co-consult or notify the provider, the nurse requested a provider follow-up in 14 days instead.

- In case 28, the patient complained of a very strong, worsening pain in the abdomen. The nurse did not assess for abdominal tenderness, listen to bowel sounds, or inquire about the last bowel movement.

- In case 32, the diabetic patient complained of bilateral foot pain and requested orthopedic shoes. However, the nurse did not inquire about the date of onset of the pain and did not assess foot pulses or sensation.

- In case 41, the patient complained of intermittent right earache and decreased hearing for two months. Although the nurse documented the tympanic membranes were intact, the nurse did not describe the appearance.[33] Additionally, the nurse did not obtain complete vital signs.

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 often documented their assessment findings and interventions satisfactorily. However, the following are examples of outpatient documentation deficiencies:

- In cases 2, 12, 13, and 16, nurses did not document descriptions of patient gait, although the assessments were clinically relevant.

- In case 32, the nurse evaluated the patient for a new infected scab on the back, which the nurse described as an "illegal tattoo." However, the nurse did not document the localization of the infection on the lower back and did not document the measurement or size of the infected scab.

Emergency Services

OIG clinicians reviewed 17 urgent or emergent events and found nine nursing deficiencies. Nurses responded promptly to emergent events. However, nurses showed

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[32] Outpatient nursing deficiencies occurred in cases 1–2, 10–16, 28–34, and 41–42. A significant nursing deficiency occurred in case 14.

[33] The tympanic membrane is also known as the eardrum, a thin tissue layer which separates from the middle ear from the external ear.

opportunities for improvement with assessments. Please refer to the **Emergency Services** indicator for further details.

Hospital Returns

OIG clinicians reviewed 12 nursing events involving returns from off-site hospitals or emergency rooms. OIG clinicians identified five nursing deficiencies, one of which was significant.[34] The nurses mostly performed sufficient nursing assessments; however, there were opportunities for improvement with reconciliation of hospital recommended medications. Please refer to the **Medication Management** indicator for further details.

Transfers

OIG clinicians reviewed 13 cases involving transfer-in and transfer-out processes. OIG clinicians did not find any patterns of deficiencies for the transfer-in process. However, in the transfer-out process, OIG clinicians found nurses did not always document the number or type of medications transferred out with the patient or document notifying the receiving institution of pending specialty consultations. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

OIG clinicians reviewed four cases with a total of 55 events, 20 of which were nursing encounters. In the OHU, OIG clinicians found nurses generally provided good care. Please refer to the **Specialized Medical Housing** indicator.

Specialty Services

OIG clinicians reviewed five cases with a total of 83 events, 18 of which included nurse evaluations prior to a procedure or upon their return from an off-site specialist appointment. OIG clinicians identified five nursing deficiencies related to specialty services. Although OIG clinicians did not find any deficiency patterns, in one case, on two separate occasions, the nurse assessments were not thorough. Please refer to the **Specialty Services** indicator for additional details. The following is an example:

- In case 14, this patient had two appointments with an off-site ophthalmologist. However, upon return, the nurses did not complete an objective eye assessment to include the appearance of the eyes or indicate if there were any problems.

Medication Management

OIG clinicians reviewed 117 events involving medication management. Nurses generally administered medications as ordered; however, they had challenges with medication reconciliation for patients returning from off-site hospitalizations. In addition, OIG clinicians found deficiencies with gaps or timeliness of delivery as it relates to medication administration. We discuss this further in the **Medication Management** indicator.

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[34] Deficiencies occurred in cases 2, 15, 17, and 43. A significant deficiency occurred in case 15.

Clinician On-Site Inspection

Our clinicians spoke with nurses and managers in the TTA, OHU, R&R, specialty clinics, outpatient clinics, and medication areas. We observed several well-attended, organized huddles with good staff participation. We found clinic staff knowledgeable and familiar with their patients. Clinic nurses reported varying numbers of patients scheduled each day, related to new patients arriving to the institution. The clinic nurses reported sick call requests ranged from 12 to 22 per day. The staff reported the biggest challenge was the volume of appointments. Nursing staff also acknowledged new leadership, and most nurses reported generally good morale; although, some nurses indicated morale could still improve.

We interviewed two LVN care coordinators. They reported CRC had four LVN care coordinators who were responsible for screenings, tracking dashboard measures, patient education, vaccinations, preparing documentation for review by the providers prior to chronic care appointments, offering medications, and reporting information in the nursing huddles.

We discussed some of our case findings with nursing leadership and they informed us they had already self-identified some areas for improvement. The CNE provided various audit tools for the sick call process, the OHU, wound care, and return from higher level of care and reported utilizing their "OIG monthly metrics" as guidance. In addition, the CNE reported implementing a staff survey to assist in identifying areas of need and promoting consistent staff engagement. Our clinicians reviewed staff training files and recent education and trainings, which included nursing documentation, full assessments, protocol competencies, and annual nursing skills.

Recommendations

- Nursing leadership should determine the root cause of challenges preventing nurses from performing complete assessments and 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 ***Adequate***	Compliance Rating and Score ***Not Applicable***

As in Cycle 6, CRC providers delivered acceptable care. Providers generally made appropriate evaluations and correctly diagnosed medical conditions. They worked with case management teams to manage chronic conditions and referred patients appropriately to specialists for a higher level of care when needed. The OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 88 medical provider encounters and identified 29 deficiencies, one of which was significant.[35] In addition, our clinicians examined the quality of care in 19 comprehensive case reviews. Of these 19 cases, we found 18 cases were ***adequate*** and one was ***inadequate***.

Outpatient Assessment and Decision-Making

Providers generally made appropriate assessments and sound medical decisions for their patients. Most of the time, providers diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to specialists when needed. However, our clinicians identified 16 deficiencies related to poor medical assessment and decision-making, one of which was significant.[36] The following is an example:

- In case 14, the provider assessed the patient who complained of loss of appetite for one month and weight loss. The provider did not evaluate for significant weight loss of 18.6 pounds within a span of a month, did not perform a physical examination, and did not order

[35] Deficiencies occurred in cases 1, 4–9, 13–19, 21, 43, and 45. A significant deficiency occurred in case 14.

[36] Deficiencies occurred in cases 4, 8, 13, 14, and 16–19. A significant deficiency occurred in case 14.

laboratory tests. Instead, the provider ordered high calorie lipid-based nutrient supplement for the patient who was prediabetic.[37]

Specialized Medical Housing

Providers generally delivered good care in the OHU. However, we identified four deficiencies related to provider care in the OHU. The following is an example:

- In case 45, the nurse co-consulted the provider on call for a patient in OHU, who had watery diarrhea three times a day for two days while taking multiple oral antibiotics, doxycycline and cefdinir. The provider prescribed anti-motility medication, Imodium AD. Having diarrhea while being on multiple antibiotics may indicate an infection with a highly contagious bacteria, Clostridium difficile. The provider should have considered placing the patient with suspected Clostridium difficile infection on contact precautions pending further diagnostic evaluation.

We further discuss specialized medical housing provider performance in the **Specialized Medical Housing** indicator.

Review of Records

Providers performed well in reviewing medical records and addressing discharge recommendations for patients returning from hospitalizations. We identified two deficiencies.[38] The following is an example:

- In case 14, the provider evaluated the patient following a hospitalization for dehydration, an abnormal pancreas, and multiple significant laboratory abnormalities. The provider endorsed the hospital discharge report, which recommended to discontinue diuretic medication, refer to a gastroenterologist, and order CT imaging of the abdomen. However, the provider did not refer to a gastroenterology specialist, order the CT of abdomen, or document the rationale.

Providers also generally performed well in reviewing patients' MARs and renewing patients' medications timely. We found one deficiency related to a provider's incomplete review of the MAR for a patient who returned from the hospital as described below:

- In case 45, the provider assessed the patient for OHU admission history and physical examination after the patient had a knee surgery. The provider documented the patient was on prophylactic blood thinner to prevent postoperative leg clots. However, the provider did not thoroughly review the MAR Summary, which documented the patient was not taking any blood thinners.

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[37] The high calorie lipid-based nutrient supplement can have a significant amount of carbohydrates, increasing sugar levels.

[38] Deficiencies occurred in cases 14 and 45.

Emergency Care

Providers usually managed patients in the TTA with urgent or emergent conditions appropriately. In addition, providers were available for consultation with TTA staff. We identified three deficiencies related to emergency care, none of which were significant.[39] The following is an example:

- In case 16, a patient who had underlying anemia was assessed by the provider in the TTA for shortness of breath and having black stools for the last two to three weeks. The provider ordered a fecal immunochemical test and blood count to assess for possible bleeding. However, the provider did not stop the medication, aspirin, which may increase the risk of bleeding.

We discussed further in the **Emergency Services** indicator.

Chronic Care

In most instances, providers appropriately managed patients' chronic health conditions, such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. CRC has an effective case management team approach to managing patients with diabetes. Nursing staff collaborated with providers as a team, focusing their care of diabetes by monitoring sugars, adjusting medications including insulin to reach glycemic goals, and educating patients. However, we identified two deficiencies related to the management of diabetes.[40] The following is an example:

- In case 6, the provider assessed a patient with uncontrolled blood sugar levels. The patient refused medications but agreed to further education with diabetic classes and dietician consultations. However, the provider requested dietician services to occur in three months instead of an earlier referral for the patient's uncontrolled diabetes.

Specialty Services

Providers appropriately referred patients for specialty consultation when needed. When specialists made recommendations, providers usually followed the recommendations appropriately and reviewed specialty reports timely. We identified two deficiencies related to the provider not following specialists' recommendations timely.[41] The following is an example:

- In case 4, the cardiologist evaluated the patient and recommended obtaining an echocardiogram and to follow up within four weeks. However, the provider ordered a follow-up referral more than seven weeks later and did not document a rationale for the delay.

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[39] Deficiencies occurred in cases 1, and 15–17.

[40] Deficiencies occurred in cases 6 and 7.

[41] Deficiencies occurred in cases 4 and 9.

We discuss providers' specialty performance further in the **Specialty Services** indicator.

Documentation Quality

Providers generally documented outpatient encounters on the same day of the encounter. Documentation is important because it shows the provider's thought process during clinical decision-making. When contacted by nurses, providers did not always document the interactions. Our clinicians found three undocumented interactions.[42] The following is an example:

- In case 17, a nurse co-consulted with the provider for the patient who presented with swelling of the left forearm, two skin abscesses, and chest pain. The provider recommended an oral antibiotic and to follow up with a nurse in three days. However, the provider did not document this in the progress note.

Provider Continuity

CRC offered good provider continuity. Providers were assigned to specific clinics taking care of assigned patients.

Patient Notification Letter

We found providers performed poorly in communicating diagnostic results to their patients with complete patient test result notification letters. These deficiencies are discussed in the **Diagnostic Services** indicator.

Clinician On-Site Inspection

At the on-site inspection, OIG clinicians attended meetings and spoke with medical leadership and providers. We attended the weekly provider meeting, with good participation by medical leadership and clinic providers. The physician on call reported on significant overnight events including TTA evaluations and required follow-up cases. We also observed morning huddles, which were well attended. Staff reported on TTA events, return from higher level of care, off-site specialty appointments, significant laboratory results, expiring prescriptions, missed medications, medication concerns, policy alerts, status of COVID-19 tests, durable medical equipment (DME) requests, and any hunger strikes. Staff assigned providers to specified clinics to ensure patients' continuity of care. Each provider was scheduled to see seven to 13 patients during the inspection. The providers expressed they were well supported from medical leadership.

[42] Deficiencies occurred in cases 15 and 17.

Recommendations

- Medical leadership should analyze the challenges in provider documentation for patient-related calls, emergency phone calls, nurse co-consultations, provider orders, and management plans in the EHRS and implement remedial measures as indicated.

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, CRC's specialized medical housing consisted of an outpatient housing unit (OHU).

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (67.5%)**

As in Cycle 6, CRC performed satisfactorily in case review for this indicator. While providers and nurses provided good care, we identified opportunities for improvement related to provider evaluations, nursing assessments, and medication management. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compared with Cycle 6, compliance testing showed CRC performed poorly overall in this indicator. Nurses performed excellently in completing initial assessments within the required time frame. In contrast, CTC showed poor medication continuity for newly admitted patients to the OHU and a poor provider completion rate for history and physical examinations within the required time frame. Considering all testing results, the OIG rated the compliance testing component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 55 OHU events that included 15 provider encounters and 20 nursing encounters. Due to the frequency of nursing and provider contacts in the specialized medical housing, the OIG bundles up to two weeks of patient care into a single event. We identified 14 deficiencies, none of which were considered significant.[43]

Provider Performance

Providers generally delivered satisfactory care. Compliance testing showed providers occasionally completed admission history and physicals without delay (MIT 13.002, 30.0%). Our clinicians found providers often made appropriate assessments and decisions, reviewed medical records thoroughly, and addressed specialists' recommendations

[43] Deficiencies occurred in cases 43–45.

timely. We identified four deficiencies, none of which were significant.[44] The following are examples:

- In case 43, the patient returned from the community hospital with recommendations to increase the dose of cholesterol medication; however, the provider did not increase the dose or document the rationale for not following the recommendation.

- In case 45, the patient complained of frequent diarrhea over an extended period of time. The initial test for the infectious cause of the diarrhea was negative. Following infectious disease specialist recommendations, the providers conducted additional testing for an infectious toxin as the possible cause; however, the providers did not consider ordering contact precautions when nurses reported the patient's roommates also developed diarrhea.

Nursing Performance

Compliance testing showed OHU nurses frequently performed timely admission assessments (MIT 13.001, 90.0%). Case reviewers also found nurses completed timely admission assessments. In addition, OHU nurses conducted regular rounds and generally provided good care. However, our clinicians found opportunities for improvement in admission nursing assessments and documentation, as follows:

- In case 45, the nurse did not complete a thorough OHU admission assessment for the patient who was discharged from the community hospital. The nurse did not assess for swelling at the surgical site, listen to the lungs, or check capillary refill.[45]

- In case 43, on multiple occasions during OHU rounds, the nurses documented the patient's skin was intact with no abnormalities; however, the patient had facial sutures and scattered abrasions.

Medication Administration

OHU staff had a mixed performance in medication administration. Compliance testing showed half the newly admitted patients received their medications within required time frames (MIT 13.003, 50.0%). Our clinicians identified three deficiencies related to medication management.[46] This is discussed further in the **Medication Management** indicator.

Clinician On-Site Inspection

At the onsite inspection, OIG clinicians toured CRC's OHU and interviewed OHU staff and nurses. The OHU contained 10 medical beds, seven of which were occupied at the

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[44] Deficiencies occurred in cases 43 and 45.

[45] Capillary refill is a test that measures changes in blood flow to the tissue. Pressure is applied to the fingernail bed until white. Then pressure is removed. Return of blood is indicated by the nail turning back to the pink tissue color. A prolonged duration for the blood to return to the tissue can indicate a medical condition.

[46] Deficiencies occurred in cases 43–45.

time of our inspection. Nurses stated the OHU was staffed with RNs, LVNs, and one provider. Our clinicians attended a well-organized huddle led by the OHU RN, with input from the provider and SRN. In further discussions with the OHU nurse, OIG clinicians were informed this nurse was not the usual assigned OHU nurse; however, this nurse was knowledgeable and well-versed in the OHU processes. In addition, the nurse shared a desktop manual that delineated the required shift responsibilities, tasks, and documentation to be completed each shift.

Compliance On-Site Inspection and Discussion

At the time of the on-site inspection, the OHU had a functional call light communication system (MIT 13.101, 100%).

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)	9	1	0	90.0%
Was a written history and physical examination completed within the required time frame? (13.002)	3	7	0	30.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	5	5	0	50.0%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	1	0	0	100%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	1	N/A
Overall percentage (MIT 13): 67.5%				

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

Recommendations

- Medical leadership should determine the challenges in providers completing the OHU history and physical examination within the time frame required by CCHCS policy, and implement remedial measures as indicated.

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* (70.5%)**

Case review found CRC generally provided satisfactory specialty services for patients. Providers made appropriate referrals and offered follow-up care after specialty services. Specialty nurses reviewed specialty service requests and appropriately scheduled patients for specialty appointments. Although TTA nurses performed acceptable assessments of patients returning from specialty appointments, case review found opportunities for improvement with providers' reviews of specialists' recommendations. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compared with Cycle 6, compliance testing showed CRC's overall performance worsened in this indicator. CRC's performance was satisfactory for providing medium- and routine-priority specialty services and in communicating denials of requests for specialty services. However, CRC scored low in providing high-priority specialty services and subsequent follow-up appointments for high-, medium-, and routine-priority specialty services, as well as in retrieving and endorsing specialty reports. Factoring in all testing results, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 69 events related to Specialty Services, which included 50 specialty consultations and procedures, one wound care provider specialty encounter, and 18 nursing encounters. We identified 17 deficiencies in this category, three of which were considered significant.[47]

Access to Specialty Services

Compliance testing showed patients almost always received specialty services with routine-priority referrals timely (MIT 14.007 93.3%). Patients often received specialty services with medium-priority referrals timely (MIT 14.004, 80.0%) but inconsistently received specialty services with high-priority referrals within the required time frame (MIT 14.001, 73.3%). CRC did not perform well in providing patients with subsequent follow-up, routine-priority, medium-priority, and high-priority specialty service

[47] Deficiencies occurred in cases 4, 7, 9, 14–16, 19–21, 43, and 45. Significant deficiencies occurred in cases 14, 20, and 43.

appointments as ordered by the provider (MIT 14.009, 62.5%, MIT 14.006, 57.1% and MIT 14.003, 62.5%). OIG clinicians identified two deficiencies related to specialty appointments.[48] The following is an example:

- In case 45, the provider ordered an infectious disease specialty referral with a high-priority time frame. However, the specialist consultation appointment occurred two days late.

Provider Performance

Providers generally ordered appropriate specialty consultations and followed specialty recommendations. However, compliance testing showed follow-up appointments with providers after specialty consultations intermittently occurred within required time frames (MIT 1.008, 59.3%). OIG clinicians identified three deficiencies in which providers did not endorse specialist reports timely, and four deficiencies in which providers did not implement specialty recommendations, none of which were significant.[49] The following are examples:

- In case 7, the provider reviewed and endorsed the specialist consultation report one day late.

- In case 9, the provider endorsed the specialist consultation report. However, the provider did not follow the specialist's recommendations to order a three-month follow-up appointment and laboratory tests. The provider did not document the rationale for not following the recommendations.

Nursing Performance

The specialty nurses often reviewed specialty service requests and appropriately scheduled patients for specialty appointments. TTA nurses generally performed thorough assessments of patients returning from specialty appointments, reviewed specialist recommendations, and communicated the recommendations to the providers. OIG clinicians reviewed 18 nursing encounters related to specialty services and identified five nursing deficiencies.[50] The following is an example:

- In case 16, the patient returned from an off-site specialty cardiology consultation. The off-site specialist canceled the scheduled procedure and performed an alternative procedure. However, the receiving nurse and specialty nurse did not notify the provider of the procedure change.

This is discussed further in the **Nursing Performance** indicator.

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[48] Deficiencies occurred in cases 14 and 45.

[49] Late endorsement deficiencies occurred in cases 7 and 14. Providers did not implement specialists' recommendations in case 4, 9, 19, and 45.

[50] Deficiencies occurred in cases 14–16.

Health Information Management

Compliance testing showed that CRC performed well in scanning specialty reports within required time frames (MIT 4.002, 86.7%). However, the providers needed improvement in reviewing specialty reports timely for routine-priority (MIT 14.008, 53.3%), medium-priority (MIT 14.005, 46.2%), and high-priority (MIT 14.002, 66.7%). Our clinicians identified two deficiencies related to scanning, retrieving, or reviewing specialty reports, one of which was significant as described below:[51]

- In case 20, the provider ordered a high-priority specialty referral for an interventional radiologist. This specialist performed an ultrasound-guided biopsy of the patient's bilateral thyroid nodules to evaluate for cancer. The procedure report was scanned into EHRS; however, the report was not forwarded to the provider for review.

Clinician On-Site Inspection

We discussed the specialty referral management process with medical and nursing leadership, providers, specialty nurses, and the utilization management nurse. CRC offers on-site specialty services including hearing aid evaluations, physical therapy, respiratory therapy, sleep studies, orthotics, optometry, and ophthalmology.

Specialty staff reported that specialty nurses reviewed referral requests, contacted specialists for available appointments, and scheduled the appointments. They described the process of obtaining off-site specialty appointments as a team process. Specifically, the utilization management nurse notified the off-site specialty nurse of approved Requests for Services (RFS), and the off-site specialty nurse processed the related documentation. The off-site specialty nurse utilized a filing cabinet tracking system organized by month and separated appointments as pending, scheduled, and completed. The off-site specialty nurse reported three nurses were cross trained in the position, and directions for using the tracking system were available. In addition, medical records staff were tasked with obtaining any consultation reports that did not accompany patients upon their return. The CRC specialty team reported challenges with obtaining high-priority appointments within compliance dates, due to off-site specialty clinic availability.

We discussed the process for ensuring specialty recommendations. Nursing leadership indicated that, as a result of the clinicians' identification in the case reviews of deficiencies this cycle with high-priority RFS follow-up appointments, leadership immediately implemented a change in their process. In the new process, the nurse who assessed the patient after a high-priority specialty referral would be the responsible person to schedule the follow-up provider appointment to occur within five calendar days. The patient care team would schedule the follow-up provider appointment for medium- and low-priority specialty referrals.

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[51] Deficiencies occurred in cases 20 and 21. A significant deficiency occurred in case 21.

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)	11	4	0	73.3%
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)	5	3	7	62.5%
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)	12	3	0	80.0%
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)	6	7	2	46.2%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	4	3	8	57.1%
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)	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	5	3	7	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)	N/A	N/A	N/A	N/A
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	20	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	16	4	0	80.0%
Overall percentage (MIT 14): 70.5%				

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

Table 18. Other Tests Related to Specialized Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	16	11	18	59.3%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	26	4	15	86.7%

* 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 identify the cause of challenges in timely completing follow-up specialty appointments and high-priority specialty appointments and should continue to implement remedial measures as appropriate.

- Medical leadership should determine the cause of challenges with timely provider review of specialty consultation 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* (64.2%)**

CRC's performance was mixed in this indicator as the institution scored well in some applicable tests yet needed to improve in several areas. The EMRRC did not review cases timely and only occasionally completed the required checklists. In addition, the institution conducted medical emergency response drills with inconsistent documentation and only occasionally completed drill forms timely. Lastly, physician managers did not complete annual appraisals in a timely manner while nurse managers did not ensure newly hired nurses received the required onboarding training. These findings are set forth in the table on the next page. Overall, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

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

The institution did not have any reported deaths during our inspection period (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)	5	1	0	83.3%
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)	0	12	0	0
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	1	2	0	33.3%
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	0	0	0	N/A
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	9	1	0	90.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	0	4	1	0
Did the providers maintain valid state medical licenses? (15.106)	7	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	5	0	2	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, 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): 64.2%

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

Recommendations

The OIG offers no recommendations for this indicator.

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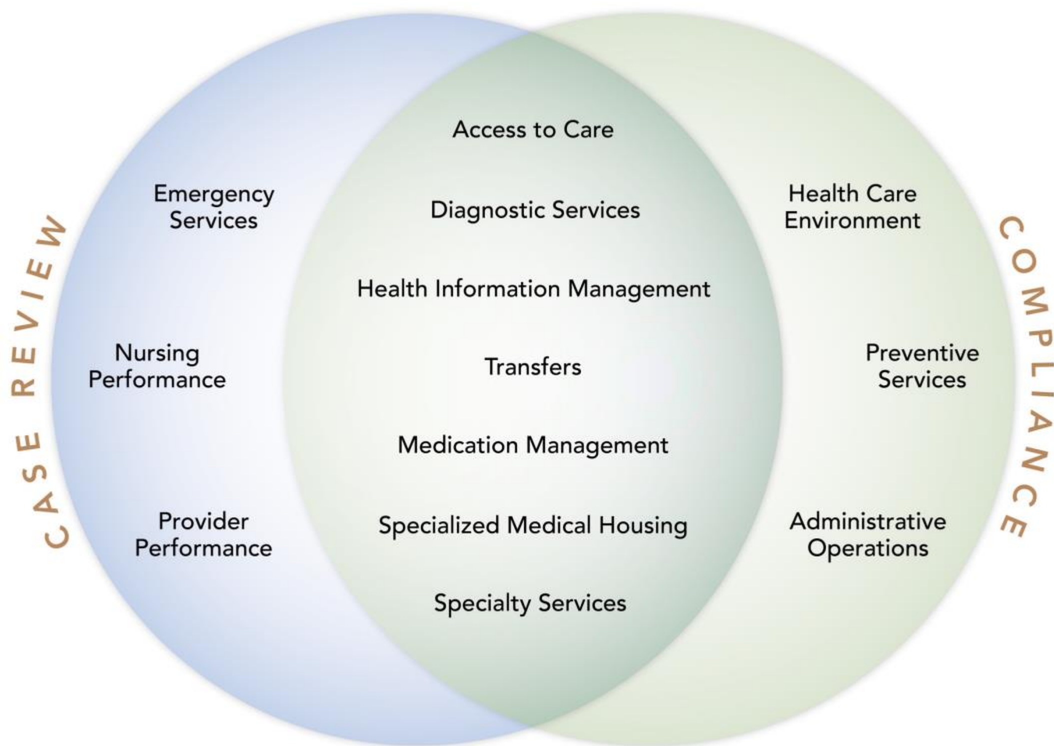
Appendix A: Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the receiver's office, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates the delivery of medical care by combining clinical case reviews of patient files, objective tests of compliance with policies and procedures, and an analysis of outcomes for certain population-based metrics.

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure A–1 below depicts the intersection of case review and compliance.

Figure A–1. Inspection Indicator Review Distribution for CRC



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

Term	Definition
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

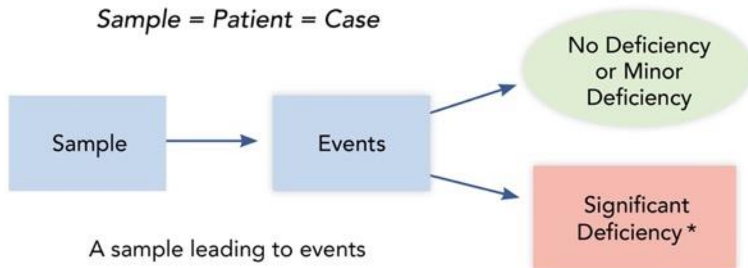
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

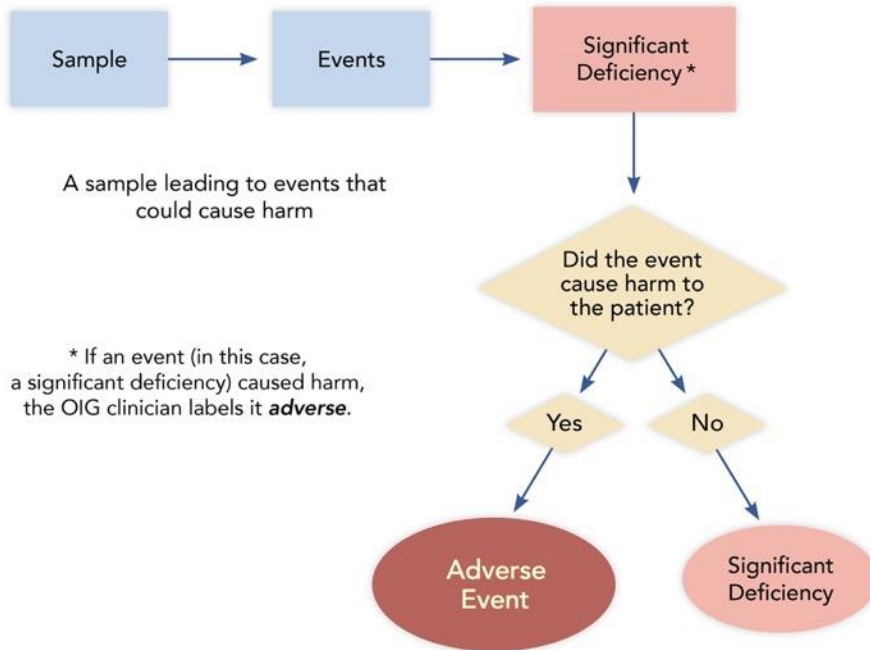
Figure A–2. Case Review Testing

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***.



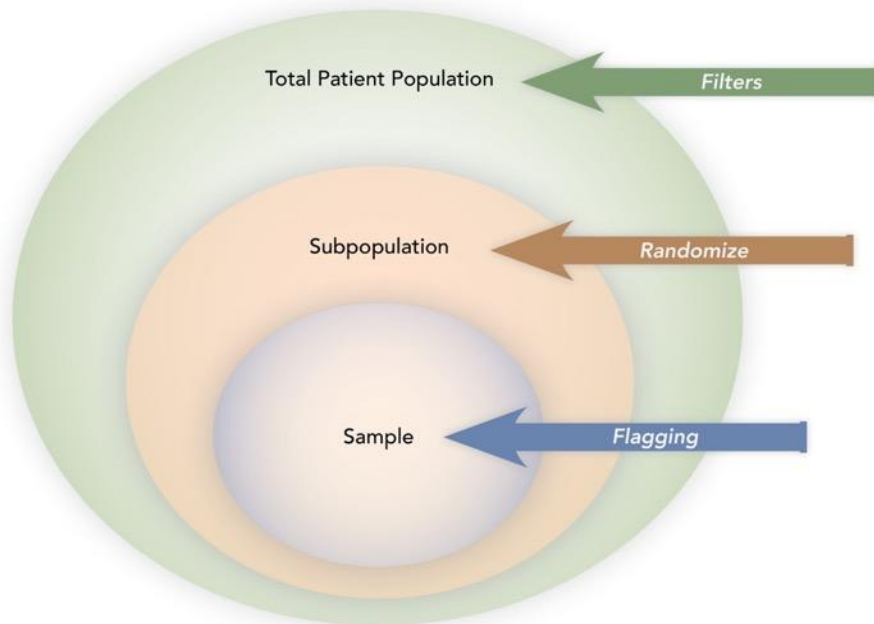
Source: The Office of the Inspector General medical inspection analysis.

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. CRC Case Review Sample Sets

Sample Set	Total
Anticoagulation	2
CTC/OHU	3
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	2
High Risk	6
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	15
Specialty Services	3
	45

Table B–2. CRC Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	2
Anticoagulation	5
Arthritis/Degenerative Joint Disease	6
Asthma	5
Cardiovascular Disease	4
Chronic Kidney Disease	3
Chronic Pain	13
Cirrhosis/End-Stage Liver Disease	1
COPD	3
COVID-19	7
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	10
Gastroesophageal Reflux Disease	4
Hepatitis C	7
Hyperlipidemia	21
Hypertension	15
Mental Health	22
Migraine Headaches	1
Seizure Disorder	1
Sleep Apnea	3
Substance Abuse	16
Thyroid Disease	2
	154

Table B–3. CRC Case Review Events by Program

Diagnosis	Total
Diagnostic Services	392
Emergency Care	29
Hospitalization	21
Intrasystem Transfers In	17
Intrasystem Transfers Out	9
Outpatient Care	279
Specialized Medical Housing	55
Specialty Services	79
	881

Table B–4. CRC Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	3
RN Reviews Detailed	12
RN Reviews Focused	28
Total Reviews	63
Total Unique Cases	45
Overlapping Reviews (MD & RN)	18

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Appendix C: Compliance Sampling Methodology

California Rehabilitation Center

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003-006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	24	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	9	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	30	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	24	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	24	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	11	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	0	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • 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	24	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	7	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	8	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	N/A at this Institution	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	25	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	10	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

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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	5	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	7	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	0	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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September 4, 2024

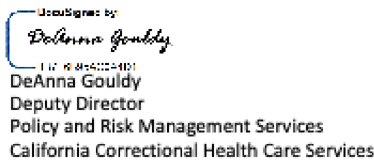
Amarik Singh, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

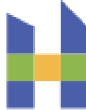
California Correctional Health Care Services has reviewed the draft Medical Inspection Report for California Rehabilitation Center (CRC) conducted by the Office of the Inspector General (OIG) from August 2022 to January 2023. Thank you for preparing the report.

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

Sincerely,



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



cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
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Cycle 7

Medical Inspection Report

for

California Rehabilitation Center

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
September 2024

OIG