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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

December 2024

Cycle 7

Medical Inspection Report

Substance Abuse Treatment Facility and State Prison at Corcoran

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Contents

Illustrations iv
Introduction 1
Summary: Ratings and Scores 3
Medical Inspection Results 5
Deficiencies Identified During Case Review 5
Case Review Results 5
Compliance Testing Results 6
Institution-Specific Metrics 7
Population-Based Metrics 10
HEDIS Results 10
Recommendations 12
Indicators 15
Access to Care 15
Diagnostic Services 21
Emergency Services 26
Health Information Management 30
Health Care Environment 36
Transfers 47
Medication Management 53
Preventive Services 61
Nursing Performance 64
Provider Performance 69
Specialized Medical Housing 74
Specialty Services 79
Administrative Operations 85
Appendix A: Methodology 89
Case Reviews 90
Compliance Testing 93
Indicator Ratings and the Overall Medical Quality Rating 94
Appendix B: Case Review Data 95
Appendix C: Compliance Sampling Methodology 99
California Correctional Health Care Services' Response 107
November 25, 2024, OIG Response to November 19, 2024, Letter Regarding SATF Report 108

Illustrations

Tables

1. SATF Summary Table: Case Review Ratings and Policy Compliance Scores 4
2. SATF Master Registry Data as of September 2023 8
3. SATF Health Care Staffing Resources as of September 2023 9
4. SATF Results Compared With State HEDIS Scores 11
5. Access to Care 18
6. Other Tests Related to Access to Care 19
7. Diagnostic Services 24
8. Health Information Management 33
9. Other Tests Related to Health Information Management 34
10. Health Care Environment 45
11. Transfers 50
12. Other Tests Related to Transfers 51
13. Medication Management 58
14. Other Tests Related to Medication Management 59
15. Preventive Services 62
16. Specialized Medical Housing 77
17. Specialty Services 82
18. Other Tests Related to Specialized Services 83
19. Administrative Operations 87

A–1. Case Review Definitions 90
B–1. SATF Case Review Sample Sets 95
B–2. SATF Case Review Chronic Care Diagnoses 96
B–3. SATF Case Review Events by Program 97
B–4. SATF Case Review Sample Summary 97

Figures

A–1. Inspection Indicator Review Distribution for SATF 89
A–2. Case Review Testing 92
A–3. Compliance Sampling Methodology 93

Photographs

1. Patient Waiting Area 37
2. Examination Room With Unsecured Medical Records 38
3. Expired Medical Supply Dated December 2022 39
4. Unlabeled and Unorganized Medical Supplies 39
5. Staff Did Not Open EMRB to Verify 40
6. Staff Did Not Perform Appropriate Tests 40
7. EMRB Glucometer Quality Control Results Were Out of Range 41

Photographs (continued)

8. Expired Medical Supplies Dated September 1, 2023, and October 10, 2022 42
9. Expired Medical Supplies Dated September 2021 42
10. Dead Insects Found on the Medical Warehouse Floor 43
11. Unsanitary Medical Room Floor 43
12. Damaged and Unsanitary Examination Room Floor 43

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Introduction

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

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

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

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

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

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

[2] The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care 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 Substance Abuse Treatment Facility and State Prison at Corcoran, 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 February 2023 to July 2023.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between August 2022 and April 2023, anticoagulation reviews between February 2023 and July 2023, and transfer reviews between February 2023 and June 2023.

Summary: Ratings and Scores

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

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

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

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 55 cases, which contained 803 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 December 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 none ***proficient***, 17 ***adequate***, and three ***inadequate***.

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 417 patient records and 1,249 data points, and used the data to answer 91 policy questions. In addition, we observed SATF's processes during an on-site inspection in September 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 SATF.

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

Table 1. SATF 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		Compliance		
		Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*
1	Access to Care	Adequate	↑	78.3%	45.9%	↑
2	Diagnostic Services	Adequate	↑	58.9%	44.7%	=
3	Emergency Services	Adequate	=	N/A	N/A	N/A
4	Health Information Management	Inadequate	=	81.0%	83.0%	=
5	Health Care Environment†	N/A	N/A	45.1%	57.1%	=
6	Transfers	Adequate	↑	75.8%	51.1%	↑
7	Medication Management	Adequate	=	42.2%	67.7%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	76.9%	60.4%	↑
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	=	66.7%	81.6%	↓
14	Specialty Services	Adequate	↑	71.8%	56.2%	=
15	Administrative Operations†	N/A	N/A	71.9%	66.5%	=

* 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 did not find any adverse events at SATF 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 SATF. Of these 10 indicators, OIG clinicians rated nine ***adequate*** and one ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 17 were ***adequate***, and three were ***inadequate***. In the 803 events reviewed, we identified 247 deficiencies, 52 of which 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 SATF:

- The institution provided excellent overall access to nurses and to providers after discharge from the hospital.
- The nurses generally performed well in ensuring medications and transfer documents were included in the transfer packet for patients who transferred out of the facility.
- The nurses often completed thorough assessments of patients returning from the hospital and adequately communicated recommendations to the provider.
- The nurses administered Narcan promptly for patients with a suspected drug overdose.
- The providers frequently documented their encounters well and adequately managed their patient's chronic medical conditions.

Our clinicians found the following weaknesses at SATF:

- The providers did not consistently include all required elements in patient test result notification letters.

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

- The nurses did not always triage the patients with symptomatic complaints within one business day.

- The nurses did not always co-consult with the provider for sick call protocol encounters when a patient's condition warranted a same day follow-up appointment.

- Patients did not always receive their chronic care, return from hospital, and transfer medications timely.

- The institution struggled to provide adequate access for specialty services.

Compliance Testing Results

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

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

- Medical staff performed well in scanning initial health care screening forms, community hospital discharge reports, and requests for health care services into patients' electronic medical records within required time frames.

- Nursing staff processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames.

- The institution performed well in offering immunizations and in providing preventive services for their patients, such as influenza vaccination, annual screening for tuberculosis (TB), and colorectal cancer screenings.

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

- SATF staff frequently did not maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to a specialized medical housing unit. In addition, SATF maintained poor medication continuity for patients who transferred into the institution, transferred within the institution, or had a temporary layover at SATF.

- Health care staff did not follow hand hygiene precautions before or after patient encounters.

- Nursing staff did not regularly inspect emergency medical response bags (EMRB) and treatment carts.

- Medical clinics at SATF did not meet requirements for essential core medical equipment and supplies. Almost all clinics we tested were missing properly calibrated medical equipment and medical supplies required to provide standard medical care.

- Providers did not often communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.

- SATF did not perform well in ensuring specialty services were provided within specified time frames.

Institution-Specific Metrics

Substance Abuse Treatment Facility and State Prison at Corcoran (SATF), located in Kings County, operates as a medium-to-high-security, and maximum-security institution for general population incarcerated people. SATF maintains medical clinics where medical staff address routine requests for medical services. SATF also conducts patient screenings in its receiving and release clinic (R&R), treats patients requiring urgent or emergent care in its triage and treatment area (TTA), and houses patients requiring inpatient health care services in its correctional treatment center (CTC). SATF has been designated as a *basic care institution* by the department. Basic care institutions are located in rural areas away from tertiary care centers and specialty care providers whose services are likely to be used frequently by higher-risk patients. Basic care institutions have the capability to provide limited specialty medical services and consultation for a generally healthy incarcerated population.

As of July 18, 2024, the department reports on its public tracker 78 percent of SATF's incarcerated population is fully vaccinated for COVID-19 while 61 percent of SATF's staff is fully vaccinated for COVID-19.[7]

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

In September 2023, the Health Care Services Master Registry showed SATF had a total population of 4,768. A breakdown of the medical risk level of the SATF population as determined by the department is set forth in Table 2 below.[8]

Table 2. SATF Master Registry Data as of September 2023

Medical Risk Level*	Number of Patients	Percentage†
High 1	307	6.4%
High 2	500	10.5%
Medium	2,556	53.6%
Low	1,405	29.5%
Total	**4,768**	**100.0%**

* Institutions designated as ***basic*** are generally expected to have a high-risk medical population of approximately 5%. At nearly 17%, SATF's high-risk population is over three times the expected ratio. However, this institution is still assigned a medical staffing package consistent with its *basic* designation. This ratio places additional strain on the institution's ability to meet the population's health care needs.

† Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated September 8, 2023.

[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, SATF had no vacant executive leadership positions, 1.5 primary care provider vacancies, 3.2 nursing supervisor vacancies, and 39.9 nursing staff vacancies.

Table 3. SATF Health Care Staffing Resources as of September 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	13.5	20.2	175.5	214.2
Filled by Civil Service	6.0	12.0	17.0	135.6	170.6
Vacant	0	1.5	3.2	39.9	44.6
Percentage Filled by Civil Service	120.0%	88.9%	84.2%	77.3%	79.6%
Filled by Telemedicine	0	2.0	0	0	2.0
Percentage Filled by Telemedicine	0	14.8%	0	0	0.9%
Filled by Registry	0	2.0	0	25.0	27.0
Percentage Filled by Registry	0	14.8%	0	14.2%	12.6%
Total Filled Positions	6.0	16.0	17.0	160.6	199.6
Total Percentage Filled	**120.0%**	**118.5%**	**84.2%**	**91.5%**	**93.2%**
Appointments in Last 12 Months	3.0	5.0	6.0	38.6	52.6
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	0	5.0	5.0
Adjusted Total: Filled Positions	**6.0**	**16.0**	**17.0**	**155.6**	**194.6**
Adjusted Total: Percentage Filled	**120.0%**	**118.5%**	**84.2%**	**88.7%**	**90.8%**

* 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 September 8, 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 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 SATF's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only two HEDIS measures are available for review: **poor HbA1c control**, which measures the percentage of diabetic patients who have poor blood sugar control, and **colorectal cancer screening** rates for patients ages 45 to 75. For poor HbA1c control, SATF's results compared favorably with those found in State health plans. 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)—SATF'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. SATF had a 49 percent influenza immunization rate for adults 18 to 64 years old and an 87 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 76 percent.[10]

Cancer Screening

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—SATF's

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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.

colorectal cancer screening rate of 79 percent was higher, indicating very good performance on this measure.

Table 4. SATF Results Compared With State HEDIS Scores

HEDIS Measure	SATF Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**5%**	36%	31%	22%
HbA1c Control (< 8.0%) ‡	88%	–	–	–
Blood Pressure Control (< 140/90) ‡	88%	–	–	–
Eye Examinations	58%	–	–	–
Influenza – Adults (18–64)	49%	–	–	–
Influenza – Adults (65+)	87%	–	–	–
Pneumococcal – Adults (65+)	76%	–	–	–
Colorectal Cancer Screening	**79%**	37%	68%	70%

Notes and Sources

* Unless otherwise stated, data were collected in September 2023 by reviewing medical records from a sample of SATF'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 *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2022–June 30, 2023 (published March - April 2024); https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Managed-Care-Technical-Report-Volume-1.pdf.

‡ For this indicator, the entire applicable SATF 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 SATF's performance, we offer the following recommendations to the department:

Diagnostic Services

- The department should consider developing strategies to ensure providers create patient notification letters when they endorse tests results and patient notification letters contain all elements required by CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely review and endorsement of radiology reports and implement remedial measures as appropriate.

Emergency Services

- Nursing leadership should determine the root cause of challenges preventing nurses from completely and accurately documenting emergent events, with all appropriate times, and should implement remedial measures as appropriate.

Health Information Management

- Medical leadership should ascertain the root cause of untimely provider endorsement of specialty reports and implement remedial measures as appropriate.

- Medical leadership should ascertain the root causes of incomplete and untimely provider review of hospital discharge reports and should 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 should take necessary remedial measures.

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

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

- Nursing leadership should determine the root cause(s) for staff both not ensuring the EMRBs are regularly inventoried and sealed as well as not properly completing the monthly logs and should take necessary remedial measures.

Transfers

- Nursing leadership should ascertain the root causes preventing R&R nurses from properly completing the initial health screening form before patients are placed in housing and thoroughly completing the initial health screening including answering all questions and documenting an explanation for each *yes* answer. Leadership should implement remedial measures as appropriate.

Medication Management

- Nursing leadership should assess the root cause for nursing staff failing to document patient refusals in the MARs, as described in CCHCS policy and procedures, and should implement remedial measures as needed.

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients and document in the MAR summaries as described in CCHCS policy and procedures.

Preventive Services

- Nursing leadership should consider developing and implementing measures to ensure nursing staff administer TB medications to patients as prescribed.

- Medical leadership should determine the cause of challenges to the timely provision of vaccinations for chronic care patients and should implement appropriate remedial measures.

Nursing Performance

- Nursing leadership should develop strategies to ensure nurses perform thorough face-to-face assessments as well as triage sick calls appropriately and should implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should develop strategies to ensure nurses in the CTC thoroughly and completely document patient care and should implement remedial measures as appropriate.

- Nursing and medical leadership should develop strategies to ensure initial assessments and history and physical examinations are completed within time frames required by CCHCS policy and should implement remedial measures as appropriate.

Specialty Services

- The department should determine the root causes of challenges to timely providing specialty appointments as well as follow-up appointments and should implement remedial measures as appropriate.

- The department should consider developing and implementing measures to ensure the institution timely receives specialty reports and providers timely review these reports.

Access to Care

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (78.3%)**

Compared with Cycle 6, case reviewers found SATF improved in providing patients with access to care. The nurses assessed the patients timely with requested appointments. However, providers needed improvement in access to care for chronic care and specialized medical housing. Providers timely evaluated patients after return from hospitalizations and after emergent treatment and triage area (TTA) events. We identified a pattern in which patients did not receive their specialty appointments within the specified time frames. After reviewing all aspects of care access, the OIG rated the case review component of this indicator ***adequate***.

SATF's performance in compliance testing was mixed in this indicator. Compliance testing showed SATF nurses performed exceptionally in reviewing patient sick call requests, completing face-to-face encounters, and referring patients to their primary care providers. However, access to providers needed improvement for chronic care appointments, newly transferred patients, and patients returning after hospitalization. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 161 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events, which required the institution to generate appointments. We identified nine deficiencies relating to **Access to Care**, five of which were significant.[11]

Access to Care Providers

SATF needed improvement in access to provider appointments. Compliance testing showed insufficient access to chronic care follow-up appointments (MIT 1.001, 60.0%) but very good access with nursing-to-provider referral appointments (MIT 1.005, 86.7%). Case

[11] Deficiencies occurred in cases 9–11, 15, 21–23, and 25. Significant deficiencies occurred in cases 9–11, 15, and 25.

review clinicians did not find any deficiencies in the timeliness of outpatient provider appointments ordered by the provider or referred by nurses.

Access to Specialized Medical Housing Providers

SATF provided excellent access to providers within specialized medical housing. The case reviewers found no deficiencies related to access to specialized medical housing providers.

Access to Clinic Nurses

SATF performed very well in access to nurse sick calls and provider-to-nurse referrals. Compliance testing showed nurses always triaged sick call requests the same day they received them (MIT 1.003, 100%) and usually performed face-to-face appointments timely (MIT 1.004, 85.0%). Our clinicians reviewed 40 nursing sick call requests and identified no deficiencies related to clinic nurse access.

Access to Specialty Services

SATF had mixed performance with access to referrals to specialty services. Compliance testing showed good subsequent follow-up to routine-priority appointments (MIT 14.009, 85.7%); however, compliance testing revealed an intermittent completion rate of high-priority (MIT 14.001, 66.7%), medium-priority (MIT 14.004, 73.3%), and routine-priority (MIT 14.007, 60.0%) appointments. Compliance testing showed the institution did very well with medium-priority (MIT 14.006, 88.9%) services, but also showed patients only sometimes received subsequent specialty follow-up appointments within the specified time frames for high-priority services (MIT 14.003, 72.7%). Case review clinicians found most specialty appointments took place within required time frames. However, we identified four deficiencies, three of which were significant.[12] The following are two examples:

- In case 11, the provider ordered a neurology appointment within 61 days. However, the appointment did not occur.

- In case 15, the provider ordered a routine-priority urology appointment, which occurred 22 days late.

Follow-Up After Specialty Services

Compliance testing revealed provider appointments after specialty services needed improvement (MIT 1.008, 73.2%). Case review clinicians identified three deficiencies related to provider follow-up after specialty services.[13] The following are examples:

- In case 9, the podiatrist evaluated the patient for an urgent consultation. The follow-up provider appointment did not occur.

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[12] Deficiencies occurred in cases 11, 15, 23, and 25.

[13] Deficiencies occurred in cases 9, 21, and 22.

- In case 22, the provider follow-up appointment with the patient after an urgent orthopedic surgery consultation was delayed by one day.

Follow-Up After Hospitalization

SATF provided very good access to provider follow-up appointments for patients who were discharged from a community hospital (MIT 1.007, 88.0%). Case review clinicians identified one deficiency in provider follow-up after hospitalization, which was not significant.

Follow-Up After Urgent or Emergent Care (TTA)

SATF providers always evaluated their patients following a TTA event as medically indicated. OIG clinicians assessed seven TTA events and identified no delays in provider follow-up appointments.

Follow-Up After Transferring Into SATF

Compliance testing showed intermittent access to intake appointments for newly arrived patients (MIT 1.002, 61.9%). Case reviewers did not find any deficiencies in this area.

Clinician On-Site Inspection

SATF had seven main clinics: Facilities A, B, C, D, E, F, and G. Each clinic had two providers. Three clinics were staffed with one telemedicine and one in-person provider. All clinics were staffed with registered nurses (RN), licensed vocational nurses (LVN), and medical assistants (MA). In addition to the provider having scheduled patient appointments, each staff member also had scheduled patient appointments. Office technicians (OT) reported their providers had no backlog during the OIG review period.

OIG clinicians observed morning huddles in the CTC and the clinics, which were well attended by the patient care team and staff. The morning huddles lasted about 15 minutes and included pertinent patient information, including TTA encounters, returns from off-site specialty services, and discharges from the hospital. OIG clinicians met with the scheduling supervisor, who stated the institution had no staffing vacancies. The scheduling supervisor also reported appointments were sometimes rescheduled due to lockdowns or adjustments made to modified yard programs. However, staff rescheduled appointments within compliance time frames.

Compliance On-Site Inspection

Three of six housing units randomly tested at the time of inspection had access to Health Care Services Request Forms (CDCR form 7362) (MIT 1.101, 50.0%). In three housing units, custody officers did not have a system in place for reordering the forms. The custody officers reported reliance on medical staff to replenish the forms in the housing units.

Compliance Score Results

Table 5. Access to Care

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	15	10	0	60.0%
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)	13	8	4	61.9%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	40	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)	34	6	0	85.0%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	13	2	25	86.7%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	2	0	38	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)	22	3	0	88.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	30	11	4	73.2%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	3	0	50.0%
Overall percentage (MIT 1): **78.3%**				

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

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

Table 6. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002)	4	2	0	66.7%
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	8	3	4	72.7%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	1	6	88.9%
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)	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	6	1	8	85.7%

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

Recommendations

The OIG offers no recommendations for this indicator.

Diagnostic Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate*** **(58.9%)**

In case review, SATF's performance varied in diagnostic services. Case reviewers did not identify any significant deficiencies in completing laboratory and radiology tests. However, the providers performed poorly in communicating radiology, laboratory, and pathology result letters to patients. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

In compliance testing, SATF's overall score was low for this indicator. Staff performed exceptionally well in completing radiology and laboratory tests and in retrieving pathology reports. However, while providers promptly endorsed laboratory results, they only intermittently endorsed radiology studies in a timely manner and rarely generated patient test result notification letters with all required elements. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 163 diagnostic-related events and found 100 deficiencies, 10 of which were significant. [14] Of the 100 deficiencies, 93 related to health information management and seven related to the noncompletion or delayed completion of ordered tests.[15]

Most deficiencies were due to patient notification letters missing some of the required elements or not being sent. Although OIG clinicians identified a high number of these deficiencies, these deficiencies did not significantly increase the risk of harm to the patients.

Test Completion

SATF performed very well in timely completing tests. Compliance testing showed excellent performance completing radiology (MIT 2.001, 90.0%) and laboratory services

[14] Deficiencies occurred in cases 1, 2, 9–11, 14, 15, 17, 19–25, 54, and 55. Significant deficiencies occurred in cases 11, 19, and 25.
[15] Deficiencies related to health information management occurred in cases 1, 2, 9–11, 14, 15, 17, 19–25, 54, and 55. Deficiencies related to noncompletion or delayed completion of ordered tests occurred in case 11.

(MIT 2.004, 90.0%) within required time frames. OIG clinicians found one significant deficiency related to test completion described below:

- In case 11, the provider ordered a urine toxicology test; however, the test was not performed, and the electronic health record system (EHRS) contained no documentation of a refusal from the patient.

Compliance testing did not have any STAT laboratory tests in their samples (MIT 2.007, N/A).

Health Information Management

SATF had variable performance in managing the results of diagnostic tests. Compliance testing showed providers usually endorsed laboratory results timely (MIT 2.005, 90.0%) but needed improvement in endorsing radiology results (MIT 2.002, 60.0%). The case reviewers identified six significant deficiencies related to the late endorsement of test results.[16] The following are two examples:

- In case 11, the provider did not endorse the coagulation test results until 30 days after the results were available.

- In case 19, the provider did not endorse blood and urine test results until 15 days after the results were available.

SATF staff performed very well in pathology report retrieval (MIT 2.010, 90.0%) and perfectly in provider review of pathology reports (MIT 2.011, 100%). OIG clinicians did not identify any deficiencies related to STAT or pathology test result retrieval or provider review.

Compliance testing revealed SATF's performance with provider communication of test results to the patients was poor. Providers never communicated to patients complete test result letters from radiology (MIT 2.003, zero) or pathology studies (MIT 2.012, zero), and rarely communicated to patients complete test result letters from laboratory studies (MIT 2.006, 10.0%) within required time frames. Case review found 93 deficiencies related to providers sending incomplete test result letters or not sending test result letters to the patient.[17]

We also discuss this in the **Health Information Management** indicator.

Clinician On-Site Inspection

The OIG clinician interviewed the senior laboratory assistant and the correctional health services administrator (CHSA). They reported the institution's staff shortages, which included a part-time radiology technician and two laboratory assistants.

SATF offered routine X-rays, computerized tomography (CT), magnetic resonance imaging (MRI), and ultrasound tests on site. The CHSA reported no backlog of diagnostic studies. The providers did not report any problems with obtaining either laboratory or

[16] Significant deficiencies occurred in cases 11 and 19.

[17] Deficiencies with patient notification letters occurred in cases 1, 2, 9–11, 14, 15, 17, 19–25, 54, and 55. None of these deficiencies were significant.

imaging studies. They seldom ordered STAT laboratory tests; however, when they did, they reported no issues with test completion or notifying patients of the results.

Compliance Score 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)	9	1	0	90.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	6	4	0	60.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	0	10	0	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)	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	9	1	0	90.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **58.9%**

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

Recommendations

- The department should consider developing strategies to ensure providers create patient notification letters when they endorse tests results and patient notification letters contain all elements required by CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely review and endorsement of radiology reports 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 solely through case review.

Ratings and Results Overview

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

SATF performed satisfactorily in providing emergency care. Staff responded to emergencies and initiated cardiopulmonary resuscitation promptly. Furthermore, staff performed well in ensuring staff timely administered Narcan for patients with suspected opioid overdose. However, our clinicians identified opportunities for improvement in nursing interventions and in documenting event time lines. SATF's performance during this cycle was similar to Cycle 6, but with fewer deficiencies. Overall, the OIG rated this indicator ***adequate.***

Case Review Results

We reviewed 21 urgent and emergent events and found 15 emergency care deficiencies. Of these 15 deficiencies, two were significant.[18]

Emergency Medical Response

SATF healthcare and custody staff responded promptly to emergencies throughout the institution and initiated CPR. Staff activated emergency medical services (EMS) and mostly notified TTA staff timely. However, case review identified one significant deficiency involving a delay in contacting TTA promptly:

- In case 2, the patient was escorted to the medical clinic with an abnormally low blood sugar reading with symptoms. The nurses administered glucose tablets with no change in the blood sugar reading. However, nursing staff delayed notifying the TTA for 24 minutes from the time the patient was initially assessed in the clinic.

[18] Deficiencies occurred in cases 2–4, 6, 8, 9, and 18–20. Significant deficiencies occurred in case 2.

Provider Performance

SATF providers performed well in urgent and emergent situations as well as in after-hours care. However, we identified one deficiency related to urgent care:[19]

- In case 2, the nurse informed the provider the patient had a critically elevated fingerstick glucose. The provider ordered additional insulin but did not evaluate for ketones in the urine, which would have required further treatment including intravenous fluids. In addition, the provider did not document a progress note to explain this medical decision.

Nursing Performance

SATF nurses usually performed appropriate nursing assessments and interventions during emergencies. However, our clinicians identified three deficiencies in which nurses did not always intervene appropriately, one of which was significant.[20] The following is an example:

- In case 2, nurses provided emergency care to the patient with a critically low blood sugar reading. The clinic nurse administered glucose gel twice; however, when rechecking the levels, the patient's blood sugar level was still low. The TTA responded, but the patient refused to be transferred to the TTA and remained in the clinic. Nursing did not continuously monitor the patient's mental status, recheck the patient's blood sugar, or consult with the provider.

Nursing Documentation

SATF nurses generally documented emergent events appropriately. However, we found opportunities for improvement in documenting the time line and sequence of events.[21] The deficiencies did not impact the overall care of the patient. The following is an example:

- In case 20, the patient, who was transferred to a higher level of care, complained of left leg pain and received emergency medical care. However, the electronic health record system showed nursing staff documented they performed patient's vital signs 11 minutes after the patient had already left the facility.

Emergency Medical Response Review Committee

The EMRRC is required to audit all unscheduled patient transports to a higher level of care to evaluate staff performance, documentation, and policy adherence as well as to identify training issues. OIG clinicians found supervising registered nurses (SRNs) completed the emergency medical response checklists for these patients. In addition, we found designated nursing and physician staff also completed these reviews. Compliance testing showed SATF's leadership performed poorly in reviewing the emergency events

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[19] A deficiency occurred in case 2.

[20] Deficiencies in nursing assessments occurred in cases 2, 3, and 6.

[21] Documentation deficiencies occurred in cases 8, 19, and 20.

within required time frames, and incident packages frequently did not include required documents (MIT 15.003, 25.0%).

Clinician On-Site Inspection

During our on-site inspection, OIG clinicians toured the TTA and had the opportunity to interview TTA nursing staff. SATF's TTA had four rooms to provide patient care along with two crash carts. The TTA had two emergency response vehicles (ERVs), one of which was used as a backup. Furthermore, the nurse commented the TTA was staffed with two registered nurses (RNs) on each shift and was sometimes staffed with a third RN, who could assist as needed. In addition, there was one provider assigned to the TTA, Monday through Friday, from 7 a.m. to 5 p.m., and after-hours and weekends. The providers rotated with on-call coverage.

Nursing staff shared they were notified by radio when emergency events occurred. The clinic RNs would initially respond to the emergency event, and TTA RNs would respond only if they were requested. After-hours and weekends, TTA RNs responded to all emergency events. TTA staff did not conduct daily huddles; communication occurred instead during shift changes. The nursing staff further stated TTA staff held monthly meetings during which various topics were discussed.

Nursing staff conveyed to us nursing morale at times was low and the institution needed improvement in training and education as well as better communication between staff and executive leadership. The nurses reported not everyone wanted to work in the TTA, and they had experiences challenges with hiring staff. In addition, the nurses reported the new chief nursing executive (CNE) had been supportive and had a positive working relationship with custody staff.

Recommendations

- Nursing leadership should determine the root cause of challenges preventing nurses from completely and accurately documenting emergent events, with all appropriate times, and should 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	Compliance Rating and Score
Inadequate	***Adequate*** **(81.0%)**

Case review showed SATF's performance declined in health information management in this cycle compared with Cycle 6. Providers sometimes endorsed specialty reports timely. Case review also found providers inconsistently endorsed laboratory and pathology results timely. In addition, providers only sporadically generated patient notification test result letters with all required components per CCHCS policy. After careful consideration, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed SATF performed sufficiently in health information management. Staff performed very well in scanning patient sick call requests, specialty service reports, and hospitalization reports. Conversely, staff needed improvement in retrieving complete hospital discharge reports and in providers timely reviewing them. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 160 events and found 105 deficiencies related to health information management, 13 of which were significant.[22]

Hospital Discharge Reports

SATF staff performed excellently in retrieving hospital discharge records, scanning them into the EHRS, and reviewing them within required time frames (MIT 4.003, 90.0%). Our clinicians reviewed 12 off-site emergency department and hospital encounters. OIG clinicians did not identify any deficiencies.

[22] Deficiencies occurred in cases 1, 2, 9–11, 14, 15, 17, 19–25, 54, and 55. Significant deficiencies occurred in cases 2, 9, 11, 19, 24, and 25.

Specialty Reports

SATF had mixed performance in managing specialty service reports. Compliance testing showed satisfactory retrieval of specialty reports (MIT 4.002, 80.0%). Providers needed improvement in timely endorsing high-priority (MIT 14.002, 50.0%) and routine-priority (MIT 14.008, 71.4%) specialty reports. However, providers usually endorsed medium-priority specialty reports within the required time frame (MIT 14.005, 80.0%).

Our clinicians reviewed 91 specialty reports and identified 24 deficiencies, nine of which were significant.[23] The significant deficiencies included staff not timely retrieving or scanning records, and providers not timely endorsing specialty reports. The following are examples of two significant deficiencies:

- In case 14, the provider endorsed an ophthalmology consultation report eight days late.

- In case 24, the health information management (HIM) staff scanned the pacemaker test report 34 days late.

Diagnostic Reports

SATF had a mixed performance in diagnostic reports management. The providers always reviewed the pathology reports on time (MIT 2.011, 100%) but never communicated pathology results to the patients (MIT 2.012, zero). OIG clinicians identified 93 deficiencies related to incomplete or missing patient results notification letters, which accounted for most diagnostic HIM deficiencies.[24] We also identified a minor pattern of deficiencies related to late provider endorsement of diagnostic results.[25] Please refer to the **Diagnostic Services** indicator for further detailed discussion about diagnostic reports.

Urgent and Emergent Records

OIG clinicians reviewed 34 emergency care events and found SATF nurses and providers recorded these events well. Providers also documented their emergency care sufficiently, including off-site telephone encounters. We did not identify any deficiencies. The **Emergency Services** indicator provides additional details.

Scanning Performance

SATF had sufficient performance in the scanning process. Compliance testing showed the institution often properly labeled, scanned, and filed documents (MIT 4.004, 75.0%). Case reviewers identified four deficiencies, none of which were significant.[26]

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[23] Specialty health information management deficiencies occurred in cases 2, 9, 11, 14, 15, 20, 21, and 23–25. Significant deficiencies occurred in cases 2, 9, 11, 15, 24, and 25.

[24] Deficiencies occurred in cases 1, 2, 9–11, 14, 15, 17, 19–25, 54, and 55. No significant deficiencies notification occurred.

[25] Deficiencies occurred in cases 10, 11, 14, 19, and 20. Six significant deficiencies occurred in cases 11 and 19.

[26] Deficiencies occurred in cases 21, 24, and 25.

Clinician On-Site Inspection

We discussed HIM with the health records technician (HRT) supervisor, who described the process of scanning off-site reports. The HRT supervisor stated HIM staff scanned reports as they received them. Regarding specialty reports, the HRT supervisor reported they did not track specialty appointments to determine whether they received reports in a timely manner.

We discussed the process of ensuring timely provider review of reports and results with the HRT supervisor during the HIM meeting. The HRT supervisor reported having not tracked whether providers reviewed and endorsed reports nor having monitored components of the patient results notification letter.

The HRT supervisor reported one HRT vacancy and no office assistant vacancies.

Compliance Score Results

Table 8. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	20	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	24	6	15	80.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	18	2	5	90.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	18	6	0	75.0%
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)	15	10	0	60.0%
Overall percentage (MIT 4): **81.0%**				

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

Table 9. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	6	4	0	60.0%
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)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	9	1	0	90.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	7	7	1	50.0%
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)	12	3	0	80.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	10	4	1	71.4%

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

Recommendations

- Medical leadership should ascertain the root cause of untimely provider endorsement of specialty reports and implement remedial measures as appropriate.
- Medical leadership should ascertain the root causes of incomplete and untimely provider review of hospital discharge reports and should implement remedial measures as appropriate.

Health Care Environment

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

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 ***Not Applicable***	Compliance Rating and Score ***Inadequate* (45.1%)**

Overall, SATF performed poorly in this indicator. In this cycle, multiple aspects of SATF's health care environment were poor: medical supply storage areas inside and outside the clinics either contained expired medical supplies or compromised sterile medical supply packaging, several clinical areas were unsanitary, emergency medical response bag (EMRB) logs were missing staff verification or inventory was not performed, several clinics did not meet the requirements for essential core medical equipment and supplies, and staff did not properly wash their hands throughout patient encounters. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Patient Waiting Areas

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

Clinic Environment

Twelve of 13 clinic environments were sufficiently conducive to medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 92.3%). In one clinic, the vital signs check station was within close proximity to the patient waiting area, which hindered auditory privacy.

Nine of the 13 clinics we observed contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 69.2%). In three clinics, the examination room had unsecured confidential medical records. In addition, in one of the three clinics, the staff's computer screen with patients' information was left unsecured (see Photo 2, next page). The remaining clinic had an examination table with a torn vinyl cover.

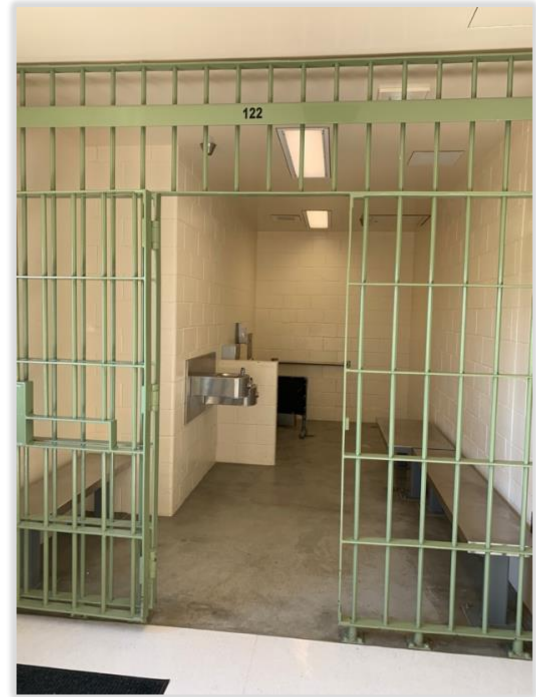

Photo 1. Patient waiting area (photographed on 9-26-23).

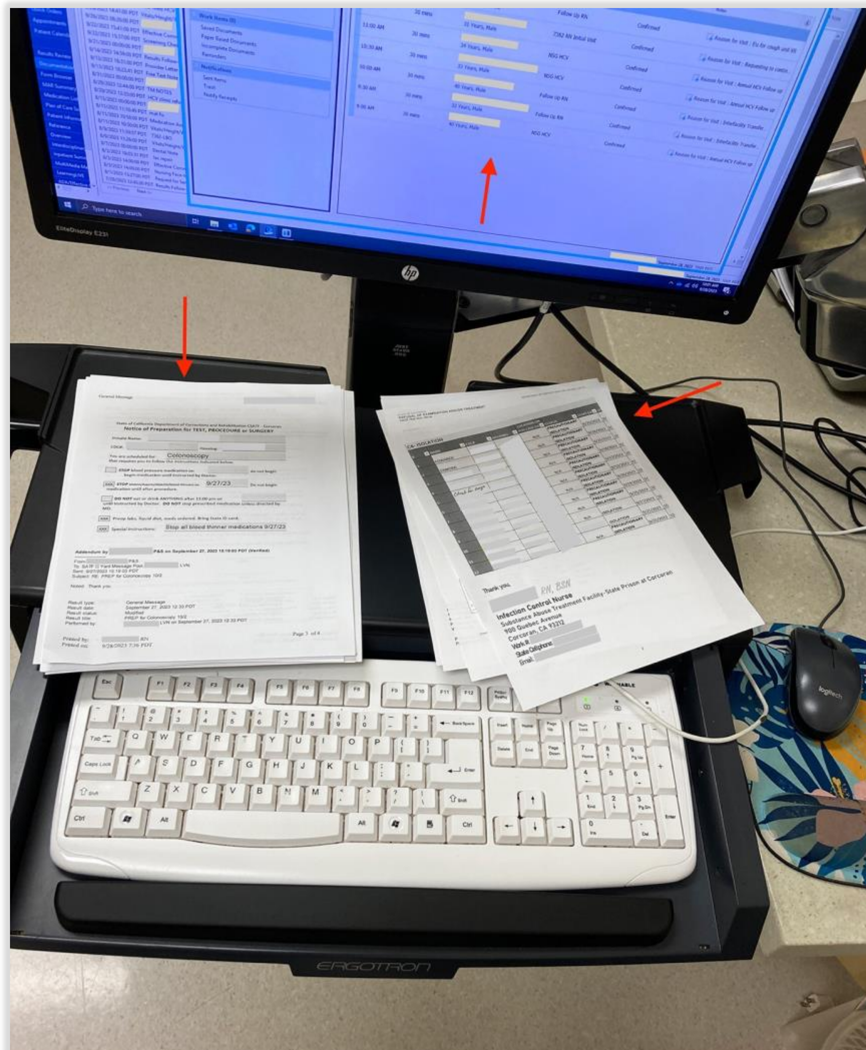

Photo 2. Examination room with unsecured physical and digital medical records (photographed 9-28-23).

Clinic Supplies

Only three of the 13 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 23.1%). We found one or more of the following deficiencies in 10 clinics: expired medical supplies (see Photo 3); compromised sterile medical supply packaging; staff members' personal items stored with medical supplies; long-term storage of staff members' food in the medical supply storage room; unorganized, unidentified, or inaccurately labeled medical supplies (see Photo 4); and cleaning materials stored with medical supplies.

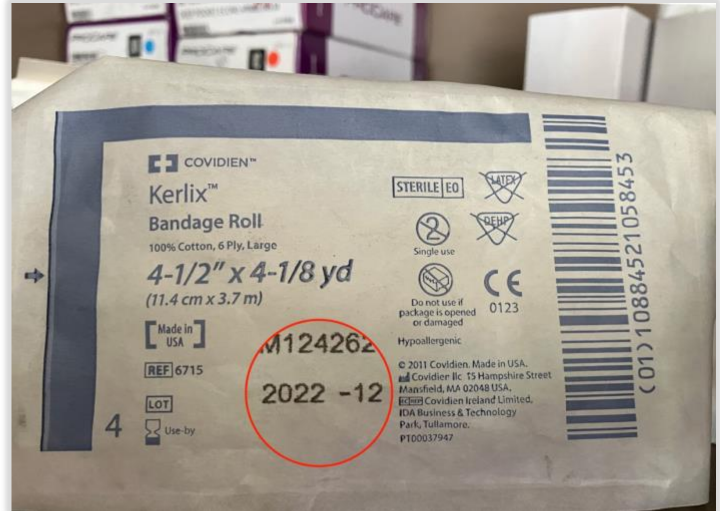

Photo 3. Expired medical supply dated December 2022 (photographed on 9-27-23).

Photo 4. Unlabeled and unorganized medical supplies (photographed on 9-27-23).

Only one of the 13 clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, 7.7%). The remaining 12 clinics lacked medical supplies or contained nonfunctional equipment. The missing medical supplies included a nebulization unit and examination table disposable paper. In addition, we found a Snellen reading chart placed at an improper distance and a nonfunctional oto-ophthalmoscope. SATF staff did not perform or properly log the results of the automated external defibrillator (AED) or the defibrillator performance tests within the last 30 days. In addition, staff did not perform daily glucometer quality control tests or accurately or completely document those test results.

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only one of the 10 applicable EMRBs passed our test (MIT 5.111, 10.0%). In nine EMRBs, we found one or more of the following deficiencies: staff did not ensure EMRB compartments were sealed and intact; staff did not complete the log documentation; staff had not inventoried EMRBs when the seal tags were replaced; and staff either logged EMRB daily glucometer quality control results incompletely or inaccurately. In addition, the TTA's treatment cart did not meet the minimum inventory level at the time of our inspection.

In addition to the above findings, our compliance inspectors observed the following recording inconsistencies in the clinics or examination rooms when they conducted their on-site inspection:

- In several clinics, SATF staff documented having verified during every shift the EMRB glucometer quality control had been performed and oxygen tank pressure was above 1,000 psi, which was the required pressure. However, the EMRB log indicated both the glucometer and oxygen tank storage compartments had not been opened because the seal tag numbers were unchanged (see Photos 5 and 6).

Photo 5. On 8-30-23 and 8-31-23, third-watch staff did not open the EMRB to verify the oxygen tank pressure because the seal tag identification numbers 1873 and 1844 did not change from second watch to third watch (photographed on 9-29-23).

In addition, staff did not document taking any corrective action and did not notify the clinic supervisor when the glucometer quality control results were out of range (see Photo 7, next page).

Photo 6. On 8-30-23, third-watch staff did not perform the glucose quality control test because the seal tag identification numbers 1943 did not change from third watch (8-29-23) to third watch (8-30-23) (photographed on 9-26-23).

ER BAG

CCHCS – GLUCOMETER QUALITY CONTROL TESTING LOG (Retention: 5 years in Clinical Laboratory)

AREA / CLINIC: STRH SERIAL #: 1040-48225483 MONTH & YEAR: August 2023

Level 1 Lot #:	123121A	Level 2 Lot #:	010322A	Level 3 Lot #:		Strip Lot #:	041223A
*Expiration Date:	12-31-23	*Expiration Date:	3-1-24	*Expiration Date:		Strip Date of First Use:	7-11-23

Date	Time	Strip Lot Exp. Date:	Level 1 Range	Result	Level 2 Range	Result	Level 3 Range	Result	Daily Cleaning	Comments	Printed Name and Initial
1	0655	8-23-24	85-106	102	212-265	255			✓		
2	0636	8-23-24	85-106	95	212-265	230			✓		
3	0630	8-23-24	85-106	90	212-265	220			✓		
4	0630	8/23/24	85-106	97	212-265	224			✓		
5	0640	8/23/24	85-106	99	212-265	280			✓		
6	0630	8/23/24	85-106	100	212-265	247			✓		
7	0645	8/23/24	85-106	90	212-265	225			✓		
8	0633	8/23/24	85-104	93	212-265	221			✓		
9	0635	8-23-24	[illegible]	102	212-265	222			✓		
10	0635	8-23-24	[illegible]	[illegible]	[illegible]	253			✓		
11	0630	[illegible]	[illegible]	101	[illegible]	263			✓		
12	0630	[illegible]	85-106	103	[illegible]	230			✓		
13	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]		
14	[illegible]	[illegible]	85-106	101	212-[illegible]	[illegible]			[illegible]		
15	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			✓		
16	[illegible]	[illegible]23	85-106	110	212-[illegible]	[illegible]					
17	[illegible]	[illegible]23	85-106	108	212-[illegible]	[illegible]					
18	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]					
19	[illegible]	[illegible]24	85-106	110	2[illegible]	[illegible]			✓		
20	[illegible]	[illegible]23	85-106	105	212-[illegible]	[illegible]			✓		
21	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			✓		
22	[illegible]	[illegible]23	85-106	101	212-[illegible]	[illegible]			✓		
23	[illegible]	[illegible]23	85-106	108	212-[illegible]	[illegible]			✓		
24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			✓		
25	063[illegible]	[illegible]	85-106	100	212-[illegible]	[illegible]			✓		
26	0630	[illegible]	85-106	98	21[illegible]	258			✓		
27	0631	[illegible]	[illegible]	[illegible]	[illegible]	237			✓		
28	0630	9-5-[illegible]	85-106	101	[illegible]	240			✓		
29	0636	9-5-23	[illegible]	[illegible]	[illegible]	[illegible]			✓		
30	0622	9-5-23	85-106	101	212-265	236			✓		
31	[illegible]	9-5-23	85-106	93	202-265	218			✓		

(Orig: CCHCS 7/2022) Glucose Monitoring – Attachment 2 Page 1 of 2

Photo 7. EMRB glucometer quality control results were out of range without documentation of corrective action or supervisor notification (photographed on 9-27-23).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics contained medical supplies stored adequately (MIT 5.106, zero). We found expired medical supplies (see Photos 8 and 9), medical supplies stored directly on the floor, compromised sterile medical supply packaging, and dead insects (see Photo 10, next page). In addition, the warehouse manager did not maintain a temperature log for medical supplies stored in the medical warehouse, which had manufacturer temperature guidelines.

Photo 8. Expired medical supplies dated September 1, 2023, and October 10, 2022 (photographed on 9-27-23).

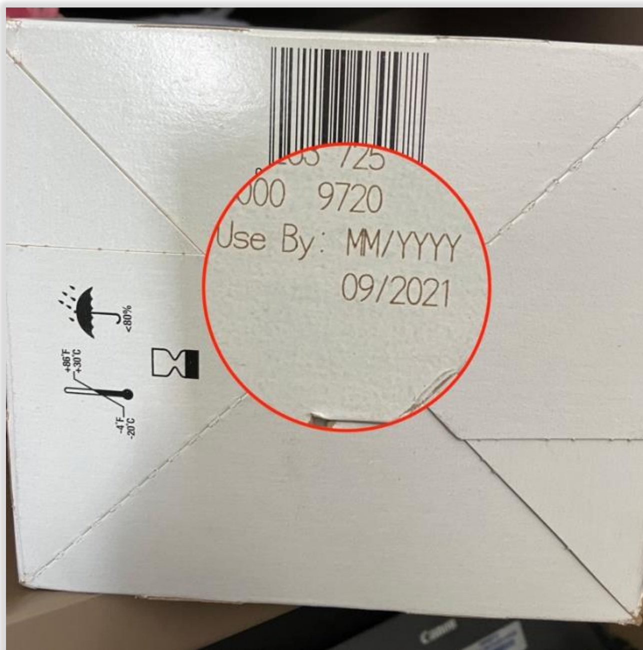

Photo 9. Expired medical supplies dated September 2021 (photographed on 9-27-23).

According to the CEO, the institution did not have any concerns about the medical supply process. Health care managers and medical warehouse managers expressed no concerns about either the medical supply chain or their communication process.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected five of 13 clinics (MIT 5.101, 38.5%). In eight clinics, we found one or more of the following deficiencies: cleaning logs were not maintained; test strips were unavailable and therefore could not be used to show whether the cleaning solution met the proper sanitation level; a clinic's gurney, a triage sink, and the medication room floor were unsanitary (see Photo 11, next page); and several clinic floors were found damaged and unsanitary (see Photo 12, next page).

Photo 10. Dead insects found on the medical warehouse floor (photographed on 9-27-23).

Photo 11. Unsanitary medical room floor (photographed on 9-26-23).

Photo 12. Damaged and unsanitary examination room floor (photographed on 9-28-23).

Staff in nine of 13 clinics properly sterilized or disinfected medical equipment (MIT 5.102, 69.2%). In four clinics, we found one or more of the following deficiencies: staff did not remove and replace the examination table paper in between patient encounters; staff did not routinely log reusable medical equipment when processed for sterilization; and when interviewed, clinical staff did not verbalize the sterilization cleaning protocols.

We found operating sinks and hand hygiene supplies in the examination rooms in eight of 13 clinics (MIT 5.103, 61.5%). In five clinics, the patient restrooms lacked antiseptic soap and disposable hand towels or had a nonfunctional hand dryer.

We observed patient encounters in 12 clinics. In nine clinics, clinicians did not wash their hands before or after examining their patients, or during subsequent regloving (MIT 5.104, 25.0%).

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

Physical Infrastructure

At the time of our medical inspection, the institution reported the health care facility improvement program had ongoing construction projects to renovate the E Yard and neutral-zone medical clinics. The institution estimated the projects were to have been completed by the fourth quarter of 2023. The institution also reported groundbreaking for the C Yard medical clinic renovation had been expected to take place in January 2023, but staff were unable to provide an estimated completion date at the time of our inspection. However, the CEO indicated the institution's ability to provide good patient care had not been negatively impacted due to the ongoing and upcoming renovations (MIT 5.999).

Compliance Score 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)	5	8	0	38.5%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	9	4	0	69.2%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	5	0	61.5%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	9	1	25.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	13	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	3	10	0	23.1%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	1	12	0	7.7%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	12	1	0	92.3%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	9	4	0	69.2%
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)	1	9	3	10.0%
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): **45.1%**

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 should take necessary remedial measures.
- Nursing leadership should both determine the root cause for staff not ensuring clinic examination rooms contain essential core medical equipment and verify staff follow equipment and medical supply management protocols. Leadership should take necessary remedial measures.
- Executive leadership should determine the root cause(s) for staff not ensuring clean and sanitary clinics, medical storage rooms, and medication rooms and should take necessary remedial measures.
- Nursing leadership should determine the root cause(s) for staff both not ensuring the EMRBs are regularly inventoried and sealed as well as not properly completing the monthly logs and should 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*** **(75.8%)**

Case review found SATF performed satisfactorily in the transfer process. Compared with Cycle 6, staff improved in completing the initial healthcare screening, ensuring patients had timely follow-up appointments after hospitalizations or emergency room encounters, and in ensuring patients transferred out of the facility with their medications. However, we identified opportunities for improvement with medication continuity for patients transferring into the facility and patients returning from hospital. Considering all information, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed mixed results with the transfer process. The institution showed good performance in ensuring transfer packets for departing patients included required documents and medications. However, SATF performed poorly in completing initial health screening forms and ensuring medication continuity for newly transferred patients. Based on the overall compliance score result, the OIG rated this indicator ***adequate.***

Case Review and Compliance Testing Results

We reviewed 24 events in 16 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified nine deficiencies, four of which were significant.[27]

[27] Deficiencies occurred in cases 18, 20, 26–29, 31, and 55. Significant deficiencies occurred in cases 27, 31, and 55.

Transfers In

Receiving nurses assessed patients appropriately, and staff scheduled provider appointments within required time frames. Compliance testing showed nurses often did not complete the initial healthcare screening form within the required time frame (MIT 6.001, 40.0%). Analysis of the compliance data showed, in 11 case samples, nurses did not complete the screening form before the patient was housed. Compliance testing and case review clinicians found SATF nurses performed very well in completing the assessment and disposition section of the form (MIT 6.002, 91.7%).

Compliance testing showed patients who transferred into SATF intermittently received their medications without interruption (MIT 6.003, 71.4%). Our analysis of the compliance data showed patients refused their medications in three samples; however, nursing did not always document the reason for refusal on the medication administration record (MAR). Case review also found patients who transferred into SATF sometimes received their medications without interruption. Our clinicians identified three deficiencies in which staff did not maintain medication continuity for patients who transferred into the institution. Please see the **Medication Management** indicator for further discussion.

Nurses intermittently administered or delivered medications without interruption for patient layovers at the institution (MIT 7.006, 60.0%). Compliance data revealed nurses did not consistently document the reason for refusal when patients refused their medications. In addition, just more than half the time, staff maintained medication continuity for patients transferring from one housing unit to another (MIT 7.005, 56.0%). Nurses usually did not document the reason for medication refusal or identify barriers when patients did not report to the medication line. Our clinicians did not find any medication deficiencies related to patient layovers or patient transfers within the institution.

Compliance testing showed patients who transferred from another facility were sometimes seen by the provider within required time frames (MIT 1.002, 61.9%). Analysis of the compliance data revealed appointments occurred between two to 25 days late. In addition, staff did not consistently schedule preapproved specialty appointments timely (MIT 14.010, 55.0%). Our clinicians did not find any deficiencies related to provider or specialty appointments.

Transfers Out

Compliance testing had only one applicable sample in which a patient transferred out of the institution. In that sample, staff performed excellently in ensuring the patient's required medications and corresponding transfer documents were included in the transfer packet (MIT 6.101, 100%). Case review found nurses mostly performed face-to-face evaluations, completed the transfer information, and administered medications prior to transfer. However, our clinicians identified one significant deficiency in which the patient was not evaluated prior to transfer:

- In case 31, the patient transferred to another facility. However, nursing did not complete a face-to-face evaluation before the patient transferred and did not communicate the patient's pending specialty appointment to the receiving facility.

Hospitalizations

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

Compliance testing showed SATF performed very well in ensuring patients had timely follow-up appointments after hospitalizations (MIT 1.007, 88.0%). The case reviewer also reached similar findings and, in addition, found nurses performed good assessments. SATF additionally performed well in retrieving and scanning hospital records (MIT 4.003, 90.0%). However, compliance testing showed providers only sometimes reviewed hospital records and reports within five calendar days of discharge (MIT 4.005, 60.0%). In some compliance samples, providers did not review hospital reports timely, and some reports did not include a date of hospital discharge.

Compliance testing showed staff sporadically maintained medication continuity for patients returning from hospitalizations (MIT 7.003, 37.5%). Our clinicians found one significant deficiency related to medication continuity for hospital returns. Please see the **Medication Management** indicator for further discussion.

Clinician On-Site Inspection

Our clinicians toured the R&R unit and had the opportunity to interview the day shift R&R RN. The nurse was knowledgeable about the transfer process and stated an average of 25 patients transfer into SATF each week, and an average of 12 patients transfer out each day. The nurse explained, when patients transfer in, staff contacted the primary provider, who reconciled all orders, and the central pharmacy filled all medications. For patients who transferred out, the pharmacy would provide a five-day supply of medication, if the medication was not on the licensed correctional clinic list.[28] Staff retrieved any patient specialty medications from the designated yard and sent them to the R&R for patient transfer.

The R&R nurse shared, when patients transferred in, staff communicated any pending specialty appointments to the primary care team and the specialty department. When patients transferred out, staff documented any pending specialty appointments on the transfer form and notified the receiving facility through the electronic health record system message pool.

The R&R nurse reported, at times, nurses did not screen patients prior to transfer because custody staff would bypass the R&R. However, the nurse explained the issue had been elevated, and a plan was in place to mitigate future occurrences. The nurse stated morale was positive, and nurses had a good working relationship with custody staff and pharmacy. Furthermore, the nurse said staff felt supported by nursing leadership.

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[28] Licensed correctional clinic stock refers to medications the pharmacy provided for medical staff to administer that are not patient-specific.

Compliance Score 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)	10	15	0	40.0%
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)	22	2	1	91.7%
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)	10	4	11	71.4%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	1	0	0	100%
Overall percentage (MIT 6): **75.8%**				

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

Table 12. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	13	8	4	61.9%
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)	22	3	0	88.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	18	2	5	90.0%
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)	15	10	0	60.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	9	15	1	37.5%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	14	11	0	56.0%
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)	6	4	0	60.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	11	9	0	55.0%

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

Recommendations

- Nursing leadership should ascertain the root causes preventing R&R nurses from properly completing the initial health screening form before patients are placed in housing and thoroughly completing the initial health screening including answering all questions and documenting an explanation for each *yes* answer. Leadership should implement remedial measures as appropriate.

Medication Management

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. 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 ***Adequate***	Compliance Rating and Score ***Inadequate* (42.2%)**

Case review found SATF performed satisfactorily in medication management. Case review found staff at the facility performed excellently in ensuring medication continuity for patients transferring out of the facility and performed well in medication continuity for new prescriptions. However, case review identified opportunities for improvement in a few cases in which staff either did not administer medications or did not administer them timely for chronic care, transfer in, specialized medical housing, and patients returning from a community hospital. Overall, the OIG rated the case review component of this indicator ***adequate***.

Compared with Cycle 6, compliance testing showed SATF performed poorly overall in medication management in Cycle 7. SATF scored low in providing patients with chronic care medications, newly prescribed medications as ordered, community hospital discharge medications, and medications for patients temporarily housed at the institution as well as medication continuity for patients transferring within the institution. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 118 events related to medications and found 17 medication deficiencies, eight of which were significant.[29]

New Medication Prescriptions

Compliance testing showed new medications were not available, or staff did not administer them timely (MIT 7.002, 48.0%). The analysis of the compliance data showed, in 13 of 25 case samples, the patients received their newly prescribed medications

[29] Deficiencies occurred in cases 9, 17, 18, 20, 26–28, and 55. Significant deficiencies occurred in cases 9, 17, 18, 27, and 55.

between one and 30 days late. Our clinicians identified one deficiency in which the patient received their newly prescribed medication two days late.[30]

Chronic Medication Continuity

Compliance testing showed SATF performed poorly in ensuring patients received their chronic care medications within required time frames. (MIT 7.001, 22.2%) Our analysis of the compliance data showed most deficiencies occurred because the pharmacy was not timely in filling and dispensing medications as ordered. In addition, some case samples showed staff did not dispense medications timely when made available, and nursing staff did not always document a reason when patients refused medication. Our clinicians identified four significant deficiencies in which patients did not receive their chronic care medications timely.[31] The following are two examples:

- In case 9, the patient did not receive their diabetic chronic care medication, empagliflozin, for the months of August and September 2023 as ordered.[32]
- In case 17, the patient did not receive needed glaucoma chronic care medication for the month of May 2023 as ordered.

Hospital Discharge Medications

Compliance testing showed SATF performed poorly in ensuring patients received their medications timely when returning from an off-site hospitalization (MIT 7.003, 37.5%). Our clinicians reviewed 12 hospital returns and identified three deficiencies, one of which was significant:

- In case 18, the patient returned from the hospital with an order to continue the antibiotic medication, doxycycline. However, the patient did not receive the medication until two days later.

Specialized Medical Housing Medications

Compliance testing showed SATF performed poorly in ensuring newly admitted patient medications were made available by the pharmacy and administered timely. (MIT 13.003, 33.3%) Our clinicians identified two significant deficiencies in one case in which the patient did not consistently receive all their nurse administered medications:

- In case 55, we identified a few days during the months of February and March 2023 on which the patient did not consistently receive the following medications: antibiotic, a blood thinner, asthma inhalers, and blood pressure medications.

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[30] The patient did not timely receive a newly prescribed medication in case 20.

[31] Patients did not timely receive, or did not receive at all, chronic care medications in cases 9 and 17.

[32] Empagliflozin is a medication used to treat type 2 diabetes. It works in the kidneys, preventing the absorption of glucose to help lower the blood sugar level.

Transfer Medications

Compliance testing showed patients who transferred into SATF intermittently received their medications without interruption (MIT 6.003, 71.4%). In addition, medications were not always administered or delivered timely for patient layovers at the institution (MIT 7.006, 60.0%). Furthermore, medication continuity was not consistently maintained for patient transfers within the facility (MIT 7.005, 56.0%). Compliance testing had one sample for a patient who transferred out with complete medications (MIT 6.101, 100%). OIG case review found SATF performed excellently in maintaining medication continuity for patients transferring out of the institution. However, we identified deficiencies in medication continuity for patients who transferred into the institution.[33] The following are two examples:

- In case 27, the patient who transferred to SATF from another facility did not arrive with the required self-administered diabetes, blood pressure, asthma, and overactive bladder medications. The provider ordered the medications on the patient's arrival. However, the patient received the medications one to two days late.

- In case 26, the patient transferred to SATF from another facility and did not arrive with the needed blood pressure medication. The provider ordered the medication; however, the patient received the medication one day late.

Medication Administration

Compliance testing showed SATF intermittently ensured TB medications were prescribed as ordered (MIT 9.001, 68.0%). At times, nursing staff did not document the reason for patient refusals or document identified barriers when patients did not report to the medication line. However, SATF performed excellently in monitoring patients taking TB medications (MIT 9.002, 96.0%). Our clinicians did not have any deficiencies related to administration of TB medications or monitoring.

Clinician On-Site Inspection

During the on-site inspection, our clinicians toured the medication clinics on E and C Yards and interviewed the licensed vocational nurses (LVNs) on E Yard. The medication administration areas were spacious, clean, and appeared well organized. The E Yard clinic was under renovation at the time of our inspection and was near completion, pending the final building inspection. In the interim, the medical staff used the chapel on the yard as an alternate space for the medication administration line. The LVNs were knowledgeable about their processes, including the KOP medication process, the emergency response process, and the transfer process.

The medication nurses stated they did not attend huddles on a regular basis because medication line times coincided with huddle times. Providers addressed any medication issues through the electronic health record system and email. In addition, the RNs reviewed the medication refill requests and notified the provider if a medication had

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[33] Patients did not timely receive transfer in medications in cases 26, 27, and 28.

expired. Otherwise, the nurse would forward the medication refill requests to the pharmacy.

We also learned breakfast times for patients occurred between 6:45 a.m. to 7:00 a.m.; however, mealtimes on each yard varied depending on which building custody released first. This could result in diabetic patients being released later. When asked about how medical staff managed diabetic patients for blood sugar checks, the nurses responded they assessed these patients for signs and symptoms when their blood sugar readings were out of range and inquired when their last meal was consumed.

The nurses reported they felt supported by their immediate supervisors and stated they had a good working relationship with custody staff.

Medication Practices and Storage Controls

The institution stored and secured narcotic medications in 10 of 11 applicable clinic and medication line locations (MIT 7.101, 90.9%). At the time of our inspection, in one location, staff reported the automated drug delivery system (ADDS) was disabled due to power supply issues. They were using a narcotic logbook as their narcotic medication storage and security downtime procedure documentation. However, the narcotic logbook was missing evidence two licensed nursing staff performed a physical inventory during a shift change, and the recorded narcotic medication balances were inaccurate and incomplete for the most recent 30 days.[34]

SATF properly secured and stored nonnarcotic medications in four of 11 applicable clinic and medication line locations (MIT 7.102, 36.4%). In seven locations, we observed one or more of the following deficiencies: the medication storage cabinet was disorganized, medication carts were unclean, the medication room lacked a clearly labeled designated area for medications to be returned to the pharmacy, nurses did not maintain unissued medication in original labeled packaging, staff did not properly and securely store medications as required by CCHCS policy, and daily security check treatment cart log entries were incomplete.

Staff kept medications protected from physical, chemical, and temperature contamination in two of the 11 applicable clinic and medication line locations (MIT 7.103, 18.2%). In nine locations, we found one or more of the following deficiencies: staff did not consistently record the room and refrigerator temperature, staff did not store internal and external medications separately, and several medication refrigerators were unsanitary.

Staff successfully stored valid, unexpired medications in 10 of the 11 applicable medication line locations (MIT 7.104, 90.9%). In one location, nurses did not label the multi-use medication as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in three of eight applicable locations (MIT 7.105, 37.5%). In five locations, some nurses neglected to wash or sanitize their hands before each subsequent regloving.

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[34] The automated drug delivery system (ADDS), also known as an automated dispensing cabinet, is used to provide drug security and tracking for controlled substances to meet all federal and state requirements.

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

Staff in one of eight applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 12.5%). In seven locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within required time frames, medication nurses did not reliably observe patients while they swallowed direct observation therapy medications, medication nurses did not crush and float the medication prior to administration as ordered by the provider, and medication nurses did not follow the CCHCS care guide when administering Suboxone medication.

Pharmacy Protocols

SATF followed general security, organization, and cleanliness management protocols in its pharmacy (MIT 7.108, 100%). However, pharmacy staff did not properly store nonrefrigerated medication off the ground (MIT 7.109, zero).

The pharmacy did not have a system in place requiring staff to properly segregate medications returned from clinical units or medication areas until such time the medications could be screened for restocking and reuse suitability (MIT 7.110, zero).

The pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC and nurses present at the time of the medication-area inspection did not correctly complete several medication-area inspection checklists (CDCR Form 7477) (MIT 7.111, zero).

We examined 13 medication error reports. The PIC timely or correctly processed only one of these 13 reports (MIT 7.112, 7.7%). For six reports, the PIC was not able to provide evidence a pharmacy error follow-up review was performed. In those six reports, we found one or more of the following deficiencies: the PIC did not complete the medication follow-up form timely, the form had no documentation of the PIC's determination or findings regarding the error, and the PIC did not document the recommended changes to correct the errors and prevent future occurrences.

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

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Nine of 10 applicable patients interviewed indicated they had access to their rescue medications. One patient showed us an unlabeled and unidentified inhaler. We promptly notified the CEO of this concern, and health care management immediately issued a replacement rescue inhaler to the patient (MIT 7.999).

Compliance Score 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)	4	14	7	22.2%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	12	13	0	48.0%
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)	9	15	1	37.5%
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)	14	11	0	56.0%
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)	6	4	0	60.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	10	1	1	90.9%
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	7	1	36.4%
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)	2	9	1	18.2%
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)	10	1	1	90.9%
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)	3	5	4	37.5%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	8	0	4	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	1	7	4	12.5%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	1	12	0	7.7%
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): **42.2%**

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

Table 14. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	10	4	11	71.4%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	1	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	17	8	0	68.0%
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)	24	1	0	96.0%
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)	2	4	0	33.3%

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

Recommendations

- Nursing leadership should assess the root cause for nursing staff failing to document patient refusals in the MARs, as described in CCHCS policy and procedures, and should implement remedial measures as needed.

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients and document in the MAR summaries as described in CCHCS policy and procedures.

Preventive Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Adequate* (76.9%)**

SATF showed satisfactory performance in providing preventive services. The institution performed excellently in monitoring patients taking TB medications, offering patients influenza vaccines for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. This institution also performed well in transferring out patients with a high risk of contracting coccidiomycosis (Valley Fever) infection and performed sufficiently in screening patients annually for TB. However, SATF needed improvement in ensuring patients took their prescribed TB medications and performed poorly in offering required immunizations to chronic care patients. Based on the overall compliance score result, the OIG rated this indicator ***adequate***.

Compliance Score 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)	17	8	0	68.0%
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)	24	1	0	96.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	20	5	0	80.0%
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	12	11	14.3%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	21	4	0	84.0%
				Overall percentage (MIT 9): **76.9%**

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

Recommendations

- Nursing leadership should consider developing and implementing measures to ensure nursing staff administer TB medications to patients as prescribed.
- Medical leadership should determine the cause of challenges to the timely provision of vaccinations for chronic care patients and should implement appropriate remedial measures.

Nursing Performance

In this indicator, 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 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***

SATF nurses delivered satisfactory care. Nurses performed good assessments and interventions for patients in the following areas: emergency, specialty, specialized medical housing, and transfers. Although nursing had fewer deficiencies compared with Cycle 6, we still found room for improvement in several areas of the nursing process, including assessments, interventions, and appropriate sick call triage. Considering all factors, the OIG rated this indicator ***adequate.***

Case Review Results

We reviewed 177 nursing encounters in 50 cases. Of the nursing encounters we reviewed, 80 occurred in the outpatient setting, and 43 were sick call requests. We identified 49 nursing performance deficiencies, six of which were significant.[35]

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. Our clinicians found nurses had opportunities for improvement with assessments and interventions. Specifically, we identified deficiencies in which nurses did not always schedule a face-to-face evaluation timely for symptomatic complaints, and

[35] Deficiencies occurred in cases 1–3, 6, 8, 9, 14, 15, 18, 21, 29, 32, 38, 39, 41, 42, 47–49, 52, 54, and 55. Significant deficiencies occurred in cases 2, 15, 47 and 49.

their assessments were often incomplete.[36] At times, nurses also did not intervene appropriately or co-consult with a provider when the patient's condition warranted. The following are examples of deficiencies we identified:

- In case 2, during the review period, the brittle diabetic patient was on an insulin sliding-scale regimen three times a day before meals.[37] However, on several occasions, the nurses did not notify the provider when the patient's blood sugar levels were out of range or recheck the patient's blood sugar reading as ordered.

- In case 15, the nurse reviewed the patient's sick call complaint for prostate issues and bladder problems. However, the nurse initiated an order for the patient to follow up with the provider in 14 days instead of initiating an RN face-to-face assessment for the symptomatic complaint in one business day. Therefore, the patient did not receive an RN face-to-face assessment for this sick call complaint.

- In case 18, the nurse assessed the patient for complaints of severe hip pain, dizziness, and elevated blood pressure. However, the nurse did not perform orthostatic blood pressure checks or co-consult with the provider to report the abnormal findings.

- In case 49, the nurse reviewed the patient's sick call complaint of pain in the left wrist and hand, causing a decrease in range of motion and difficulty with hand grip. However, the nurse initiated an order for the patient to follow up with the provider in 14 days instead of initiating an RN face-to-face assessment for the symptomatic complaint in one business day. Therefore, the patient did not receive an RN face-to-face assessment for this sick call complaint.

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. Although nurses generally performed well in documenting their assessment findings and interventions, OIG clinicians identified examples of outpatient documentation deficiencies as follows:

- In case 2, the nurse documented administering glucose tablets to the diabetic patient, who had an abnormally low blood sugar reading. However, the nurse did not document the times they completed the blood sugar recheck or the times they administered the glucose.

- In case 14, the nurse assessed the patient for complaint of a rash. However, the nurse did not document the size or description of the

[36] Deficiencies in which the nurse did not assess the patient within one business day occurred in cases 2, 15, 47, and 49.

[37] Brittle diabetes is a form of diabetes involving frequent and severe swings in blood glucose levels, which can be difficult to manage.

rash. In addition, the nurse documented the patient's skin was intact with no abnormalities but also documented the patient had impaired skin integrity.

Emergency Services

We reviewed 21 urgent or emergent events. Nurses performed satisfactorily in providing emergency care. However, nursing interventions and documentation showed room for improvement, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 12 events involving returns from off-site hospitals or emergency rooms. The nurses performed good nursing assessments, which we detail further in the **Transfers** indicator.

Transfers

We reviewed 12 cases involving transfer-in and transfer-out processes. The nurses assessed patients who transferred in and mostly screened patients appropriately when they transferred out. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed four cases with a total of 31 events. Overall, nurses performed timely assessments and evaluated patients frequently. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed seven cases in which patients had returned from off-site appointments after specialty procedures and consultation appointments. Nurses mostly performed good assessments and communicated findings and recommendations to the providers. Please refer to the **Specialty Services** indicator for additional details.

Medication Management

OIG clinicians examined 118 events involving medication management and found nurses usually administered patients' medications as prescribed. Please refer to the **Medication Management** indicator for further details.

Clinician On-Site Inspection

Our clinicians spoke with nurses and nursing supervisors in the TTA, CTC, R&R, outpatient clinics, medication areas, and scheduling. We attended two well-organized care-team huddles on E Yard and C Yard. Each care team consists of a primary care provider, a primary care RN, an MA, and an LVN care coordinator.

The clinic RN for the E Yard reported seeing an average of 15 to 20 patients a day. At the time of our inspection, the RN line had a backlog of four, and the provider line had a backlog of 206, due to the clinic renovation and staff being off work for the holidays. The

C Yard clinic did not have a backlog for any medical lines. Furthermore, staff stated an additional provider line was scheduled on weekends, and an additional RN line was scheduled on the third watch to reduce the backlog.

Our clinicians interviewed the clinic LVN care coordinator on the E Yard. The LVN shared her role consisted of managing patient registries, including colon cancer screening, immunizations, and diabetics.

Staff in the outpatient clinics reported they felt supported in their roles, and nursing morale was positive. Nursing supervisors stated the new CNE was doing an “amazing job,” and they received the support they needed. The supervisors also reported staffing was previously a challenge; however, they recently hired many contract staff to fill the vacancies.

Recommendations

- Nursing leadership should develop strategies to ensure nurses perform thorough face-to-face assessments as well as triage sick calls appropriately and should implement remedial measures as appropriate.

Provider Performance

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

Ratings and Results Overview

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

SATF providers generally delivered good medical care. Compared with Cycle 6, providers improved significantly. Providers sufficiently documented their medical decision-making and addressed their patients' acute and chronic conditions. They also made accurate assessments and appropriate treatment plans. In addition, providers delivered adequate care in the CTC and emergency settings. However, we identified instances in which providers did not always review patient medical records thoroughly or document having had nurse co-consultations. Moreover, providers could improve in sending complete patient test result notification letters. The OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 130 provider encounters and identified 59 deficiencies related to provider performance, 15 of which were significant.[38] In addition, our clinicians examined the quality of care in 20 comprehensive case reviews. Of these 20 cases, we found 17 ***adequate*** and three ***inadequate***.[39]

Outpatient Assessment and Decision-Making

Providers usually made appropriate assessments and sound medical decisions for their patients. They generally took good histories, formulated adequate differential diagnoses, and correctly referred patients to specialists. However, our clinicians identified 10 deficiencies related to poor assessments and decision-making.[40] The following deficiencies illustrate poor decision-making:

- In case 9, the provider endorsed laboratory results that included an elevated white blood cell (WBC) count and ordered a follow-up

[38] Deficiencies occurred in cases 1, 2, 4, 8–12, 15–21, and 23–25. Significant deficiencies occurred in cases 2, 9, 16, and 18–21.

[39] We rated cases 2, 16, and 19 ***inadequate***.

[40] Deficiencies with assessments and decision-making occurred in cases 8, 9, 11, 12, 18–21, and 23.

appointment with the patient to occur within seven days. Since an elevated WBC count can indicate a severe systemic infection, the provider should have evaluated the patient sooner.

- In case 19, the provider evaluated the patient with a history of idiopathic thrombocytopenic purpura (ITP) and prior hospital admission for treatment of a critically low platelet level.[41] The provider did not consider ordering repeat laboratory tests to confirm the low platelet levels.

- In case 20, the provider saw the patient who had anemia but did not consider a workup to determine the cause of the anemia.[42]

Emergency Care

In the TTA, providers usually managed patients with urgent and emergent conditions appropriately. In addition, providers were available to consult with TTA staff. We identified four deficiencies with emergency care, none of which were significant. We also discuss provider performance in emergent situations in the **Emergency Services** indicator.

Specialized Medical Housing

Providers performed excellently for patients housed within the correctional treatment center (CTC). We identified one deficiency related to review of records, which was not considered significant. We also discuss specialized medical housing provider performance in the **Specialized Medical Housing** indicator.

Specialty Services

Providers appropriately referred patients for specialty consultation when needed. When specialists made recommendations, providers usually followed the recommendations. We also discuss provider performance further in the **Specialty Services** indicator.

Outpatient Review of Records

Review of medical records is critical to ensure an appropriate treatment plan for a condition. We identified seven deficiencies related to poor review or lack of review of medical records.[43] The following are three examples of significant deficiencies:

- In case 2, the provider increased a patient's long-acting insulin but did not review the patient's chart, which showed the patient had multiple episodes of hypoglycemia. This increased the patient's risk for complications resulting from low blood sugar.

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[41] ITP is an autoimmune condition that results in dangerously low platelet count, which increases the risk for life-threatening bleeding and usually requires treatment in the hospital with immune-acting agents.

[42] Anemia is a low red blood cell count, which can be caused by inadequate red blood cell production, red cell destruction, or loss of red blood cells from the body.

[43] Deficiencies occurred in cases 2, 9, 16, and 23. Significant deficiencies occurred in cases 2, 9, and 16.

- In case 9, the provider evaluated the patient, who had an abnormally high cholesterol level that required therapeutic intervention. The provider did not document or prescribe a statin, a medication that lowers cholesterol levels and reduces the risk of stroke or heart attack.

- In case 16, the provider evaluated the patient, who had high cholesterol, for follow-up. However, the provider did not document having reviewed the MAR, which showed the patient's prescription for rosuvastatin, a cholesterol-lowering medication, was inactive.

Chronic Care

Providers generally managed their patients' chronic health conditions well. However, we identified some deficiencies related to poor decision-making.[44] These included suboptimal review of outpatient finger-stick glucose readings and recommendations for routine vaccinations. The following are examples:

- In case 2, the provider evaluated the patient with brittle diabetes after he was seen in the TTA for symptomatic hypoglycemia. The provider did not change the patient's diabetes regimen and scheduled a follow-up to occur within six months, despite that an earlier follow-up was medically indicated.

- In case 21, the provider evaluated the patient with a history of cancer but did not recommend the pneumococcal vaccine.[45] This vaccination was medically indicated to reduce the risk of bacterial pneumonia.

Outpatient Documentation Quality

Documentation provides insight into the provider's pattern of thinking and medical decision-making. Clinician reviewers identified a minor pattern of providers not documenting progress notes when performing a co-consultation with a nurse. Our clinicians found five deficiencies related to the absence of documentation when the nurse contacted provider, but none were considered significant.[46]

Patient Notification Letter

Providers often did not send patient notification letters to patients. When they did, the letters only sometimes contained all four elements required by policy. We found these types of deficiencies in 15 of the 20 detailed cases we reviewed.[47] Further discussion can be found in the **Health Information Management** indicator.

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[44] Deficiencies occurred in cases 9, 11, 12, and 19–21. Significant deficiencies occurred in cases 2, 11, and 21.

[45] The CDC recommends the pneumococcal vaccine for patients with cancer. https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf

[46] Documentation deficiencies occurred in cases 2, 10, 12, 18, and 20.

[47] Deficiencies related to incomplete or missing patient notification letters occurred in cases 1, 2, 9–11, 14, 15, 17, 19–25, 54, and 55.

Outpatient Provider Continuity

Provider continuity was excellent, and providers followed their patients over time. Most patients were usually seen by their primary care provider. Even with cases in which multiple providers treated a patient, we found no lack of continuity.

Clinician On-Site Inspection

OIG clinicians attended clinic huddles, which included both in-person and telemedicine providers. The patient care team discussed patients who had emergent symptoms or returned from off-site specialty services. Providers and nurses delivered updates regarding a change in a patient's status, including new symptoms or abnormal results that required follow-up. The patient care team showed a detailed understanding of the patients.

OIG physicians met with the chief medical executive (CME) and two chief physician and surgeons (CP&S). Medical leadership stated three in-person providers were on long-term leave. Due to these vacancies, the institution used three telemedicine providers who consistently worked in the clinic. The CME and the CP&Ss reported experiencing difficulty in hiring—but not in retaining—providers due to the facility's location. They described holding daily provider meetings in the morning in which the on-call provider reported on significant patient events, including patients being sent to the emergency room and patients returning from a higher level of care. In addition, providers discussed complex cases and opportunities for improvement in various aspects of patient care during weekly meetings.

Providers reported good morale and stated medical leadership was supportive of their needs. They felt comfortable in discussing challenging patients and clinical scenarios with the CME and the CP&Ss. In addition, they reported ancillary staff adequately addressed their needs in the clinic. They mentioned having good rapport with custody staff and having had no issues despite intermittent clinic disruptions due to yard incidents.

Recommendations

The OIG offers no recommendations for this indicator.

Specialized Medical Housing

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (66.7%)**

In case review, SATF overall provided good clinical care in the CTC. Case review found providers made accurate assessments and sound decisions. The nurses performed timely assessments, assessed patients frequently, and initiated thorough care plans. Compared with Cycle 6, the institution improved and had fewer deficiencies this cycle. However, we identified a few deficiencies in nursing documentation, which did not impact overall patient care. Considering all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compared with Cycle 6, compliance testing showed SATF overall performed poorly in this indicator for Cycle 7. Staff did not complete admission assessments and history and physical examinations within required time frames. We also found poor medication continuity for patients newly admitted to the specialized medical housing unit. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed four CTC cases that included 10 provider events and 21 nursing events. Due to the frequency of nursing and provider contacts in specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified nine deficiencies, two of which were significant.[48]

Provider Performance

Providers generally delivered good care within the CTC. However, compliance testing showed providers needed improvement in completing admission history and physical examinations (MIT 13.002, 66.7%). Our case review clinicians found the providers made good assessments, showed appropriate medical decision-making, and ensured patients

[48] Deficiencies occurred in cases 21, 23, 54, and 55. Significant deficiencies occurred in case 55.

receive specialty consultations. We only identified one provider deficiency, which was not significant.[49]

Nursing Performance

Compliance testing showed more than half the initial assessments occurred within required time frames (MIT 13.001, 66.7%). Our analysis of the compliance data showed, in two cases, nurses completed the admission assessment between two and six hours late. Our clinicians found nurses generally performed good assessments and conducted regular rounds. We identified a pattern of deficiencies related to nursing documentation, but the deficiencies did not impact the overall care of patients.[50] An example of an opportunity for improvement is shown below:

- In case 21, during the period from May 2023 to July 2023, CTC nurses rarely documented the percentage of liquid nutrition supplement consumed by the patient, who was receiving chemotherapy.

Medication Administration

Compliance testing showed SATF performed poorly in ensuring the pharmacy timely made medications for newly admitted patients available and timely administering the medications (MIT 13.003, 33.3%). Our clinicians identified three deficiencies related to medication management, two of which were significant. We also discussed these in the **Medication Management** indicator.

Clinician On-Site Inspection

Our clinicians interviewed the CTC's day shift nursing supervisor and learned the CTC had 18 medical beds, 20 mental health crisis beds, and 10 negative pressure rooms. At the time of our inspection, the CTC had a full census. The nursing supervisor stated the CTC was staffed with a mixed ratio of RNs, PTs, LVNs, and a shift lead nurse for the day and evening shifts.

The nursing supervisor reported holding daily huddles and monthly staff meetings, during which medical staff discussed supply issues and other quality of care concerns. In addition, the supervisor held population management meetings every other Tuesday. Furthermore, the supervisor discussed the various monthly audits staff performed for nursing performance and mental health. When asked about audit review findings, the supervisor reported documentation was an area needing improvement and, when the supervisor identified issues, nurses received on-the-job training.

At the time of our inspection, the nursing supervisor reported the call light system was not working; however, staff performed checks every 15 minutes for all patients. The nursing supervisor stated a work order for the call light system had been submitted.

Staff reported some of the challenges they experienced included staffing shortages. Moreover, they stated they do not always receive support from executive staff and felt the institution did not use available resources to resolve these concerns. However, overall,

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[49] The deficiency occurred in case 23.

[50] Documentation deficiencies occurred in cases, 21, 54, and 55.

staff expressed their belief the new CNE had been supportive and had been a positive change in the CTC. Furthermore, staff shared they felt good rapport among the clinical staff, and the relationship with custody staff was cohesive.

Compliance On-Site Inspection

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

Compliance Score Results

Table 16. Specialized Medical Housing

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	4	2	0	66.7%
Was a written history and physical examination completed within the required time frame? (13.002)	4	2	0	66.7%
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)	2	4	0	33.3%
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): **66.7%**				

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

Recommendations

- Nursing leadership should develop strategies to ensure nurses in the CTC thoroughly and completely document patient care and should implement remedial measures as appropriate.
- Nursing and medical leadership should develop strategies to ensure initial assessments and history and physical examinations are completed within time frames required by CCHCS policy and should implement remedial measures as appropriate.

Specialty Services

In this indicator, OIG inspectors evaluated the quality of specialty services. 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* (71.8%)**

Case review found SATF managed specialty services satisfactorily. We did not identify significant deficiencies in providing access to specialty services. In addition, providers appropriately ordered follow-up appointments after initial specialty consultations. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed a mixed performance in this indicator. Access to off-site specialists could be improved. Preapproved specialty services for newly arrived patients sometimes occurred within required time frames. Furthermore, performances in retrieving specialty reports and prompt provider endorsements varied. Based on the overall compliance score result, the OIG rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

OIG clinicians reviewed 147 events related to Specialty Services, which included 112 specialty consultations. We identified 24 deficiencies in this category, nine of which were significant.[51]

Access to Specialty Services

SATF offered variable timely access to specialists. Compliance testing showed the institution usually provided timely subsequent follow-up for medium-priority (MIT 14.006, 88.9%) and routine-priority specialty appointments (MIT 14.009, 85.7%). However, compliance testing showed the institution needed improvement in providing timely high-priority (MIT 14.001, 66.7%), medium-priority (MIT 14.004, 73.3%), and routine-priority specialty appointments (MIT 14.007, 60.0%). Furthermore, SATF only sometimes provided subsequent follow-up specialty appointments for high-priority referrals (MIT 14.003, 72.7%). Lastly, SATF needed improvement in ensuring specialty access for patients who transferred into the institution with a preapproved specialty request (MIT 14.010, 55.0%).

[51] Deficiencies occurred in cases 2, 9, 11, 14, 15, 20, 21, and 23–25. Significant deficiencies occurred in cases 2, 9, 11, 15, 24, and 25.

Case reviewers found four deficiencies with specialty services access, three of which were significant.[52] The following are examples:

- In case 15, the provider requested a routine-priority urology consultation; however, the consultation occurred 22 days late.
- In case 25, the patient had a follow-up appointment with the general surgeon; however, the appointment occurred five days late.

We note, however, the issues with access to specialty care, described above, are likely due in some part to the extraordinarily high ratio of high-risk patients who require specialty care housed at this institution, despite the institution being rated and staffed as a *basic* institution due to its remote location.[53]

Provider Performance

Providers generally ordered appropriate specialty consults and followed specialty recommendations. However, we identified deficiencies related to the provider not following the specialist's recommendation or not adequately following up on denied referrals as illustrated below:[54]

- In case 19, the provider evaluated the patient at a follow-up appointment for a denied referral of an upper endoscopy to evaluate for varices in a patient with cirrhosis.[55] The provider did not review the denied referral with the patient or consider reordering the procedure, which was medically indicated.
- In case 20, the urologist evaluated the patient and recommended the patient continue taking a medication to control an overactive bladder. However, the provider ordered a second medication from the same drug classification and did not document the medical indication.

Nursing Performance

We reviewed 36 nursing events in seven cases in which patients returned to the institution after specialty procedures and consultation appointments. Overall, the nurses mostly performed good assessments, reviewed specialty reports, communicated with the provider as necessary, and documented as required. We identified four deficiencies, but none were significant. The deficiencies related to incomplete assessments, provider notification, and initiating a provider follow-up appointment.[56]

Health Information Management

Compliance testing showed providers struggled with timely review of specialty reports for high-priority (MIT 14.002, 50.0%) and routine-priority services (MIT 14.008, 71.4%).

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[52] Deficiencies occurred in cases 10 and 16. Significant deficiencies occurred in cases 11, 15, and 25.

[53] Please refer to page 8, Table 2 and Footnote 9.

[54] Deficiencies occurred in case 19 and 20.

[55] Varices are dilated veins. These can occur in the esophagus and stomach due to liver cirrhosis.

[56] We reviewed the following specialty cases for nursing encounters: 14, 15, 17, 20, 21, and 54. Deficiencies occurred in cases 5, 10, and 21.

However, providers usually timely reviewed medium-priority specialty reports (MIT 14.005, 80.0%). SATF health information staff usually scanned specialty reports into the EHRS in a timely manner (MIT 4.002, 80.0%). Case review found minor deficiency patterns in specialty health information management. Specifically, we identified 14 health information management deficiencies of two types: in eight deficiencies, staff scanned documents late, and in six deficiencies, providers endorsed reports late.[57] We also discuss this in the **Health Information Management** indicator.

Clinician On-Site Inspection

We discussed specialty health information management processes with SATF's HRT supervisor, who explained the utilization management (UM) and specialty nurse provided reports to the HIM department. HIM staff then scanned the off-site reports into the EHRS and routed the reports to providers for review. The HIM supervisor stated the specialty department tracked whether they timely received reports from the specialists.

We met with the specialty SRN and UM RN to discuss specialty services care. They reported a backlog of on-site physical therapy, optometry, and ophthalmology appointments. In addition, they stated the institution encountered difficulties in obtaining appointments for neurology, neurosurgery, and urology. They attributed this to a shortage of specialty providers in the community, likely due in part to the institution's remote location, as well as to a backlog in telemedicine specialty appointments. They reported a backlog for telemedicine providers within allergy, ENT, neurology, neurosurgery, orthopedic surgery, transgender medicine, and urology. The SRN explained CCHCS headquarters scheduling staff oversaw telemedicine appointments, but when the compliance date approached and no providers were available, schedulers would request the patient be seen off site, which exacerbated the existing backlog.

The SRN reported UM and specialty nurses tracked specialty referrals and coordinated with the office technicians to ensure they scheduled appointments by the compliance dates. Upon the patient's return from an off-site specialty appointment, the TTA nurse reviewed and communicated about the recommendations via EHRS with the specialty nurse and the patient care team. The patient care team then discussed the patient's return from a specialty service during the morning huddle and entered orders under the direction of the primary care provider. The SRN stated they encountered difficulties in obtaining specialty reports timely. Sometimes patients would return with preliminary recommendations, but a final report was more difficult to retrieve despite numerous attempts to contact the specialist.

[57] Deficiencies occurred in cases 2, 9, 14, 20, 21, and 23–25. Significant deficiencies occurred in cases 2, 9, 24, and 25.

Compliance Score Results

Table 17. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	7	7	1	50.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	8	3	4	72.7%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	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)	8	1	6	88.9%
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)	9	6	0	60.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	10	4	1	71.4%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	6	1	8	85.7%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	11	9	0	55.0%
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)	11	8	1	57.9%
Overall percentage (MIT 14): **71.8%**				

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

Table 18. Other Tests Related to Specialized Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	30	11	4	73.2%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	24	6	15	80.0%

* 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

- The department should determine the root causes of challenges to timely providing specialty appointments as well as follow-up appointments and should implement remedial measures as appropriate.
- The department should consider developing and implementing measures to ensure the institution timely receives specialty reports and providers timely review these reports.

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* (71.9%)**

SATF's performance was mixed in this indicator. While SATF scored well in some applicable tests, it needed improvement in several areas. The Emergency Medical Response Review Committee (EMRRC) occasionally completed the required checklists and reviewed the cases within required time frames. Meeting minutes from the local governing body were missing approval documentation. In addition, the institution conducted medical emergency response drills with incomplete documentation. Physician managers only sometimes timely completed probationary and annual performance appraisals. Finally, the nurse educator only intermittently ensured the nurses who administered medication completed their annual competency testing within required time frames. These findings are set forth in the table on the next page. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

We reviewed SATF's root cause analysis of reported incidents. During our testing period, SATF submitted one report to the CCHCS Health Care Incident Review Committee (HCIRC). The root cause analysis report did not meet reporting requirements per CCHCS policy (MIT 15.001).

We obtained CCHCS Mortality Case Review reporting data. Ten patient deaths occurred during our review period. We found no evidence in the submitted documentation the preliminary mortality reports had been completed. These reports were overdue at the time of the OIG's inspection (MIT 15.998).

Compliance Score Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	3	9	0	25.0%
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)	0	4	0	0
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	10	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	6	4	0	60.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	5	5	0	50.0%
Did the providers maintain valid state medical licenses? (15.106)	15	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
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): **71.9%**

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

Recommendations

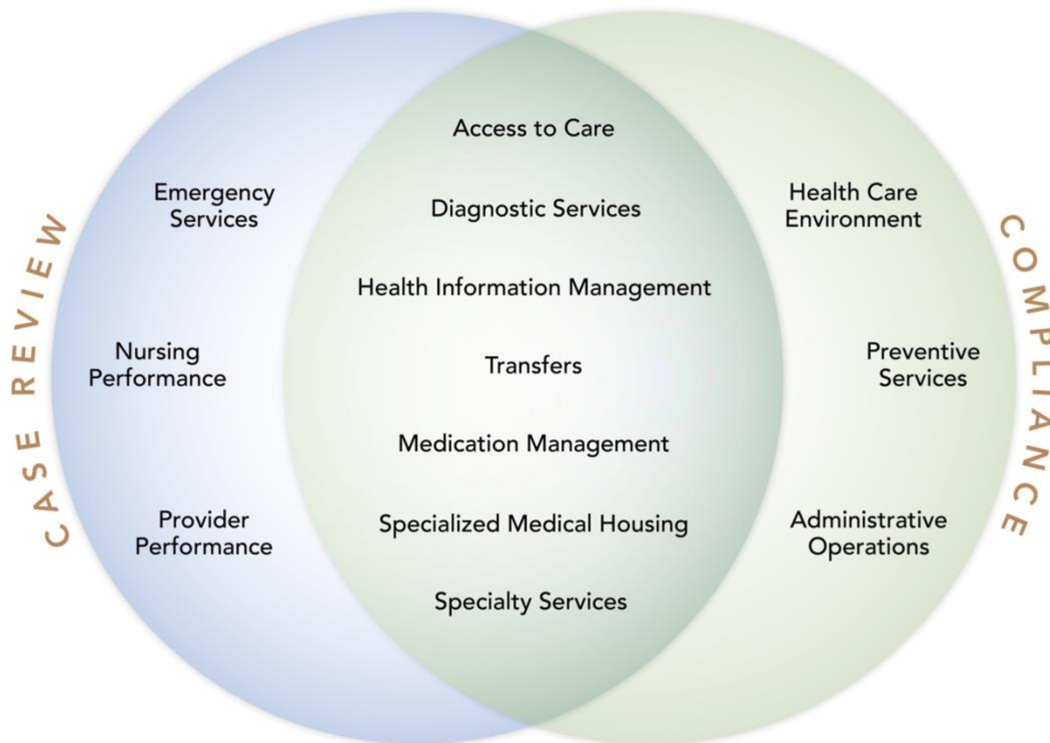
The OIG offers no recommendations for this indicator.

Appendix A: Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the receiver's office, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program 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 SATF



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

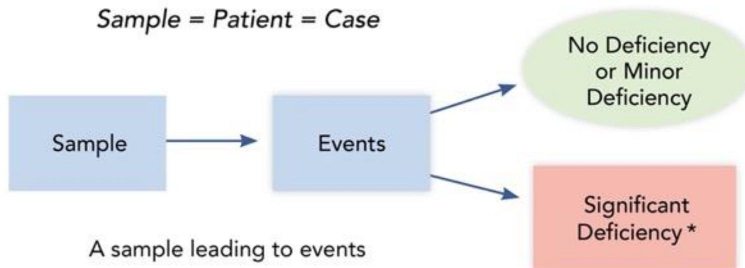
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

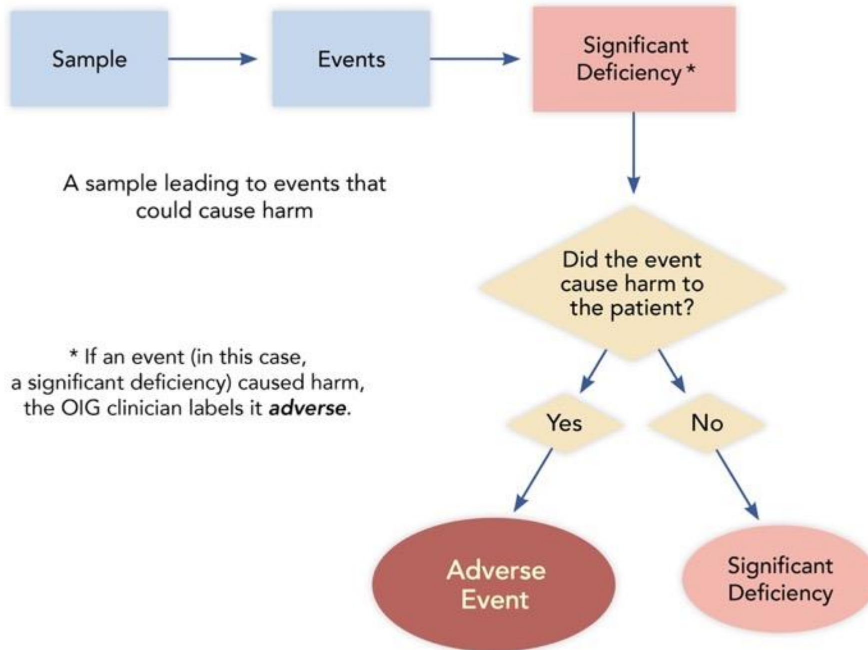
Figure A–2. Case Review Testing

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***.



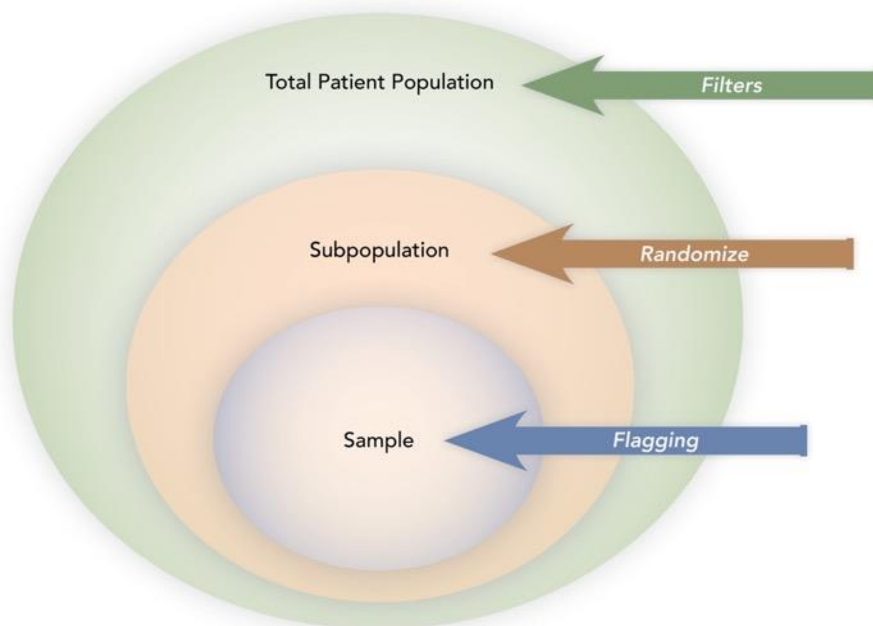
Source: The Office of the Inspector General medical inspection analysis.

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. SATF Case Review Sample Sets

Sample Set	Total
Anticoagulation	2
CTC/OHU	2
Death Review/Sentinel Events	2
Diabetes	2
Emergency Services – CPR	5
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	22
Specialty Services	4
	55

Table B–2. SATF Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	4
Anticoagulation	4
Arthritis/Degenerative Joint Disease	1
Asthma	6
COPD	2
COVID-19	2
Cancer	3
Cardiovascular Disease	3
Chronic Kidney Disease	5
Chronic Pain	12
Cirrhosis/End-Stage Liver Disease	5
Coccidioidomycosis	2
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	10
Gastroesophageal Reflux Disease	7
Hepatitis C	14
Hyperlipidemia	19
Hypertension	26
Mental Health	22
Seizure Disorder	3
Sleep Apnea	2
Substance Abuse	18
Thyroid Disease	3
	174

Table B–3. SATF Case Review Events by Program

Diagnosis	Total
Diagnostic Services	175
Emergency Care	37
Hospitalization	21
Intra-System Transfers In	7
Intra-System Transfers Out	5
Outpatient Care	348
Specialized Medical Housing	41
Specialty Services	169
	803

Table B–4. SATF Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	2
RN Reviews Detailed	22
RN Reviews Focused	24
Total Reviews	68
Total Unique Cases	55
Overlapping Reviews (MD & RN)	13

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Appendix C: Compliance Sampling Methodology

Substance Abuse Treatment Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	40	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	25	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	0	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	20	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	25	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	25	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	13	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	1	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	25	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	10	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	13	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	10	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	25	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	6	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	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports

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	10	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	15	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	10	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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November 19, 2024

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

Dear Ms. Singh:

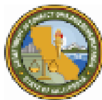
California Correctional Health Care Services has reviewed the draft Medical Inspection Report for Substance Abuse Treatment Facility (SATF) conducted by the Office of the Inspector General from February 2023 to July 2023. Thank you for preparing the report. While CCHCS disagrees with the findings for the compliance portion of the OIG Inspection for SATF, we understand that the OIG is forming a workgroup to revise the Medical Inspection Tool to reduce or eliminate subjectivity and complex, compound questions that make it difficult for CCHCS to determine areas of policy non-compliance. CCHCS looks forward to participating in such efforts and urges the OIG to begin the process as soon as possible.

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: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region III, CCHCS
Chief Executive Officer, SATF
Heather Pool, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Amanda Elhardt, Report Coordinator, OIG



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

November 25, 2024, OIG Response to November 19, 2024, Letter Regarding SATF Report

STATE of CALIFORNIA
OIG | OFFICE of the INSPECTOR GENERAL

Amarik K. Singh, *Inspector General*
Neil Robertson, *Chief Deputy Inspector General*

Independent Prison Oversight

Regional Offices
Sacramento
Bakersfield
Rancho Cucamonga

November 25, 2024

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

Dear Ms. Gouldy:

OIG RESPONSE TO NOVEMBER 19, 2024, CCHCS LETTER REGARDING SATF REPORT

The OIG provided CCHCS the Cycle 7 draft report package for Substance Abuse Treatment Facility and State Prison (SATF) on October 30, 2024 to review and provide feedback in accordance with our longstanding practice of resolving CCHCS's disputes with the OIG's medical inspection findings. Following the 30-day dispute period, CCHCS did not raise any concerns with any of the findings the OIG identified with respect to SATF's compliance testing. However, your formal November 19, 2024 Response Letter regarding the SATF medical inspection report states "CCHCS disagrees with the findings for the compliance portion of the OIG Inspection for SATF." Bypassing our long-standing dispute resolution process and simply asserting vague disagreement with our draft findings does not add value or transparency to the medical inspection process and does not permit the OIG an opportunity to reconsider the specific findings that CCHCS disagrees with.

Your formal response also claims the OIG's Medical Inspection Tool (MIT) contains subjective, complex, and compound questions that are difficult for CCHCS to understand. The MIT, which the OIG amends quarterly in collaboration with CCHCS and other stakeholders, is modeled after the policies CCHCS has formalized in its Health Care Department Operations Manual (HCDOM). The wording and the requirements of each MIT standard are taken directly from the different HCDOM rules and requirements that CCHCS has formulated with the expectation that its own staff can understand and implement. While the OIG's MIT critical review workgroup is in the process of considering whether to separate its compound testing questions, every compound question in the MIT was initially vetted for testing in that manner because the HCDOM itself requires each data point of these tests to be true to meet a singular HCDOM

Gavin Newsom, *Governor*

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Ms. DeAnna Gouldy, Deputy Director
November 25, 2024
Page 2

requirement. If the testing measures are difficult for CCHCS to comprehend, CCHCS ought to consider HCDOM revisions to clarify the health care rules by which they intend to operate.

If CCHCS has specific concerns with any of our compliance testing findings, we encourage you to raise these issues via our longstanding dispute resolution process so we are able to consider any evidence or information we may have overlooked during the compliance testing process.

Sincerely,

Amarik Singh (Nov 25, 2024 09:47 PST)

Amarik K. Singh
Inspector General
Office of the Inspector General

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Federal Receiver
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
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Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region III, CCHCS
Dr. Anu Banerjee, Chief Executive Officer, SATF
Heather Pool, Chief Assistant Inspector General, OIG
Medical Inspection Unit Management Team, OIG
Shaun Spillane, Chief Counsel, OIG

Cycle 7

Medical Inspection Report

for

Substance Abuse Treatment Facility and State Prison at Corcoran

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
December 2024

OIG