



Roy W. Wesley, Inspector General

Bryan B. Beyer, Chief Deputy Inspector General

OIG | OFFICE of the INSPECTOR GENERAL

Independent Prison Oversight

September 2020



Cycle 6 Medical Inspection Report

*California State Prison
Solano*

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

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

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

Contents

Introduction	1
Summary	3
<i>Overall Rating: Adequate</i>	3
Medical Inspection Results	7
Deficiencies Identified During Case Review	7
Case Review Results	7
Compliance Testing Results	8
Population-Based Metrics	9
HEDIS Results	9
Recommendations	11
Indicators	13
Access to Care	15
Diagnostic Services	22
Emergency Services	26
Health Information Management	30
Health Care Environment	35
Transfers	41
Medication Management	47
Preventive Services	55
Nursing Performance	56
Provider Performance	61
Specialized Medical Housing	66
Specialty Services	69
Administrative Operations	75
Appendix A: Methodology	77
Case Reviews	78
Compliance Testing	81
Indicator Ratings and the Overall Medical Quality Rating	82
Appendix B: Case Review Data	83
Appendix C: Compliance Sampling Methodology	86
California Correctional Health Care Services' Response	93

Illustrations

Tables

1. SOL Summary Table	3
2. SOL Policy Compliance Scores	4
3. SOL Master Registry Data as of August 2019	5
4. SOL Health Care Staffing Resources as of August 2019	6
5. SOL Results Compared With State HEDIS Scores	10
6. Access to Care	20
7. Other Tests Related to Access to Care	21
8. Diagnostic Services	25
9. Health Information Management	33
10. Other Tests Related to Health Information Management	34
11. Health Care Environment	40
12. Transfers	45
13. Other Tests Related to Transfers	46
14. Medication Management	53
15. Other Tests Related to Medication Management	54
16. Preventive Services	55
17. Specialized Medical Housing	68
18. Specialty Services	73
19. Other Tests Related to Specialty Services	74
20. Administrative Operations	76
A-1. Case Review Definitions	78
B-1. Case Review Sample Sets	83
B-2. Case Review Chronic Care Diagnoses	84
B-3. Case Review Events by Program	85
B-4. Case Review Sample Summary	85

Figures

A-1. Inspection Indicator Review Distribution for SOL	77
A-2. Case Review Testing	80
A-3. Compliance Sampling Methodology	81

Photographs

1. Indoor Patient Waiting Area	36
2. Additional Indoor Patient Waiting Area	36
3. Examination Room Lacking Visual Privacy	37
4. EMRB Compartments Left Unsealed	38

Cover: Rod of Asclepius courtesy of [Thomas Shafee](#)

Introduction

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

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

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

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

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

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

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

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

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

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

We completed our sixth inspection of SOL, and this report presents our assessment of the health care provided at that institution during the inspection period between February 2019 and July 2019.⁵ Notably, our report of SOL was not impacted by the novel coronavirus disease pandemic (COVID-19). The data we obtained for SOL predates COVID-19, so neither case review nor compliance testing were affected. Similarly, the on-site regional nurse review was not impacted by COVID-19.

SOL is located in the city of Vacaville and operates as a medium-security institution housing general population inmates. It is designated as an intermediate care prison, providing outpatient health care services through its nine clinics, which handle nonurgent requests for medical services. Patients needing urgent or emergent care are treated in its triage and treatment area (TTA) and patients requiring inpatient health services are cared for in its correctional treatment center (CTC).

5. Samples are obtained per the case review methodology shared with Stakeholders in prior cycles. The case review samples include cardiopulmonary resuscitation (CPR) events that occurred between December 2018 and July 2019; death reviews that occurred between January 2018 and July 2019; and registered nurse sick calls that occurred between February 2019 and September 2019.

Summary

We completed the Cycle 6 inspection of California State Prison (SOL) in November 2019. OIG inspectors monitored the institution's delivery of medical care that occurred between February 2019 and July 2019.

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



Table 1. SOL Summary Table

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

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

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

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

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 400 patient records and 1,172 data points and observed SOL's processes during an on-site inspection in September 2019. They used the data to answer 95 policy questions. Table 2 below lists SOL's average scores from Cycles 4, 5, and 6.

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 60 cases, which contained 1,018 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in October 2019 to verify their initial findings. Of the 1,018 individual health care events, the OIG clinicians identified

Table 2. SOL Policy Compliance Scores

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	75%	74%	92%
2	Diagnostic Services	69%	69%	56%
4	Health Information Management	58%	86%	76%
5	Health Care Environment	62%	66%	76%
6	Transfers	92%	67%	67%
7	Medication Management	77%	64%	79%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	82%	69%	70%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	98%	93%	82%
14	Specialty Services	66%	70%	84%
15	Administrative Operations	78%	70%	71%

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

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

268 deficiencies. Sixty-three of these deficiencies were of such a magnitude that our clinicians felt they resulted in potential significant risk of harm to patients.

The OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our clinicians rated 19 *adequate* and six *inadequate*. Our clinicians found no adverse events during this inspection.

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

In June 2019, the Health Care Services Master Registry showed that SOL had a total population of 4,613. A breakdown of the medical risk level of the SOL population as determined by the department is set forth in Table 3 below.

Table 3. SOL Master Registry Data as of August 2019

Medical Risk Level	Number of Patients	Percentage
High 1	420	9.1%
High 2	685	14.8%
Medium	1,143	24.8%
Low	2,365	51.3%
Total	4,613	100.0%

Source: Cycle 6 medical inspection preinspection questionnaire staffing matrix received on May 28, 2019, from California State Prison, Solano.

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

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, SOL had two vacant primary care provider positions, one vacant nurse supervisor position, and 17 vacant nurse positions. At the time of the OIG's inspection, six of SOL's medical staff were on extended leave from the institution.

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

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	5	11	11	122.3	149.3
Filled by Civil Service	5	9	10	105.3	129.3
Vacant	0	2	1	17	20
Percentage Filled by Civil Service	100%	81.8%	90.9%	86.1%	86.6%
Filled by Telemedicine	0	1	0	0	1
Percentage Filled by Telemedicine	0	9.1%	0	0	9.0%
Filled by Registry	0	1	0	3	4
Percentage Filled by Registry	0	9.1%	0	2.5%	12.0%
Total Filled Positions	5	11	10	108.3	134.3
Total Percentage Filled	100%	100%	90.9%	88.6%	90.0%
Appointments in Last 12 Months	0	3	5	14	22
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	1	5	6
Adjusted Total: Filled Positions	5	11	9	103.3	128.3
Adjusted Total: Percentage Filled	100%	100%	81.2%	84.5%	85.9%

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

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

Source: Cycle 6 medical inspection preinspection questionnaire staffing matrix received on May 28, 2019, from California State Prison, Solano.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency.

An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.⁷

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

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to SOL. Of these 10 indicators, OIG clinicians rated two *proficient*, six *adequate*, and two *inadequate*. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 19 were *adequate* and six were *inadequate*. In the 1,018 events reviewed, there were 268 deficiencies, 63 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at SOL:

- SOL providers made good assessments and decisions overall, particularly in their emergency medical responses in the triage and treatment area (TTA) and at the correctional treatment center (CTC). At the CTC, providers completed history and physical examinations within the time frames required by policy and evaluated patients within the time frames required by policy.
- The clinical performance of SOL nurses in the TTA and at the CTC was competent.
- The institution provided good access to clinic providers and to follow-up appointments after TTA visits, hospitalizations, and specialty visits.
- The institution retrieved hospital discharge records and specialty reports timely.

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

Our clinicians found SOL could improve in the following areas:

- Staff should correctly reconcile medications and orders when a patient transfers into the institution or returns from a hospitalization.
- Providers should consistently document progress notes during emergency care.
- Nurses should document full wound care assessments and specialist recommendations.
- The institution should ensure medication continuity when a patient is transferring into the institution or returning from a hospital as well as for patients who require chronic care medication. Making medications *request refill* as opposed to *auto refill* was a contributing factor for lapses in chronic care medications and hospital return medications.
- The institution should schedule wound care on weekends and holidays when providers request it.
- During the transfer process, medical staff should fully complete initial health screenings and reconcile medications and previously approved specialty appointments.
- Nurses should timely relay *stat* (immediate) laboratory results to providers.

Compliance Testing Results

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

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

- Nursing staff received and reviewed health care request forms and performed face-to-face evaluations timely. In addition, SOL housing units contained an adequate supply of health care request forms.
- Patients with chronic care conditions and those returning from outside community hospitals or specialty services appointments saw their primary care providers within the specified time frames.
- The institution completed high-priority, medium-priority, and routine specialty services within the required time frames. Furthermore, providers promptly communicated specialty services reports to their patients.

- SOL adhered to general security protocols and maintained the organization and cleanliness of the pharmacy area. The pharmacy staff properly accounted for all controlled substances. In addition, the institution's pharmacist followed appropriate medication error reporting protocols.

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

- Patients did not always receive their chronic care medications within the required time frames. There was poor medication continuity for patients returning from hospitalizations, for patients admitted to specialized medical housing, for patients transferring into SOL, and for patients laying over at SOL.
- Providers were often late in communicating diagnostic services, and patient letters were missing key elements required by CCHCS policy.
- The institution did not consistently provide routine and stat laboratory services within the specified time frames.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores, but the OIG obtained Kaiser Medi-Cal HEDIS scores through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report* to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

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

Comprehensive Diabetes Care

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

Table 5. SOL Results Compared With State HEDIS Scores

HEDIS Measure	SOL Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	100%	87%	95%	95%
Poor HbA1c Control (> 9.0%)‡§	14%	35%	24%	19%
HbA1c Control (< 8.0%)‡	76%	54%	63%	71%
Blood Pressure Control (< 140/90)‡	92%	66%	76%	85%
Eye Examinations	80%	61%	75%	84%
Influenza—Adults (18–64)	56%	–	–	–
Influenza—Adults (65+)	85%	–	–	–
Pneumococcal—Adults (65+)	87%	–	–	–
Colorectal Cancer Screening	83%	–	–	–

Notes and Sources

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

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

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

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

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

Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. SOL had a 85 percent immunization rate for adults 18 to 64 years old, and a 87 percent immunization rate for adults 65 years of age and older. The pneumococcal vaccination rate was 83 percent.

Cancer Screening

Statewide comparative data were not available for cancer screening; however, we include this data for informational purposes. In colorectal cancer screening, SOL had an 83 percent screening rate.

Recommendations

The OIG recommends the following quality improvement initiatives:

- The department should consider how to address the disconnect between the standard order time frame and the time frame providers request in their requests for services.
- Medical leadership should remind providers to reconcile pending specialty consultations after a patient returns from the hospital.
- Scheduling supervisors should ensure that daily wound care appointments occur on weekends and holidays as ordered.
- Medical leadership should access and review line providers' electronic health record system (EHRS) inboxes to ensure that staff providers timely review diagnostic results.
- The department should clarify whether it is the responsibility of specialty telehealth providers or the responsibility of the primary care provider to follow up with patients after specialty laboratory test results are received.
- Medical leadership should remind providers of which diagnostic studies require approval from utilization management.
- Medical leadership should remind providers to document their emergency encounters.
- Nursing leadership should remind nurses to thoroughly complete and accurately document all medical assessments.
- Medical leadership should ensure that emergency medical response bags are regularly sealed and inventoried.
- Medical leadership should ensure that clinic common areas and examination rooms contain essential core medical equipment and supplies.

- Medical staff should be reminded to follow universal hand hygiene precautions. Implementing random spot checks may help with compliance.
- Nursing leadership should monitor the performance of receiving and release (R&R) staff to ensure they thoroughly complete nursing assessments, perform appropriate nursing interventions, and document the continuity of chronic care medication.
- The department should clarify staff responsibilities of reconciling preapproved specialty orders and ensuring medication continuity.
- Pharmacists should contact the provider when they consider changing prescriptions to *request refill*.
- Nursing leadership should remind medication nurses to ensure accurate medical administration record documentation.
- Out-to-medical nurses should receive refresher training to reconcile all medications upon a patient's return to the institution.⁸
- Institutional leadership should remind providers to reconcile medications at every appointment.
- Nursing leadership should remind nursing staff that at least one pill line staff member should attend daily huddles.
- R&R staff should undergo additional training on completing keep-on-person (KOP) medication documentation for layover patients in the administration segregation unit.
- Nursing leadership should remind nurses to complete assessments and wound care as ordered.
- Nursing leadership should remind nurses to notify providers of specialists' recommendations.
- Medical leadership should remind providers to document physician-on-call and TTA encounters.
- Institutional leadership should review and delineate providers' responsibilities for reconciling medications and orders upon a patient's arrival or return to the institution.
- Institutional leadership should continue to support collaboration between providers, nurses, custody staff, and ancillary staff.
- Institutional leadership should ensure that newly admitted CTC patients receive their medications timely to maintain medication continuity.
- Executive leadership should review and define staff responsibilities of ordering preapproved specialty services for patients newly arriving to the institution.

8. An out-to-medical nurse is a type of nurse who assesses patients upon their return to the institution after receiving an off-site specialty service.

- Executive leadership should review and define staff responsibilities for reconciling all orders upon a patient's return from the hospital.
- Medical records staff should perform routine scheduled reviews to ensure the review and endorsement of specialty reports.
- Medical leadership should remind providers about their specialty ordering process.
- The Emergency Medical Response Review Committee (EMRRC) should review emergency medical response incidents timely at the regular monthly meeting following the date of the incidents.
- Nursing leadership should ensure that annual clinical competency testing for nursing staff is conducted timely.

(This page left blank for reproduction purposes.)

Access to Care

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

Results Overview

Despite provider and nursing shortages, SOL provided adequate access in most clinical areas. Case review clinicians found that patients had good access to clinic providers and to follow-up appointments after TTA visits, hospitalizations, and specialty visits and that staff performed well in these areas. We found room for improvement in access to specialty services, as we found a pattern of delays in scheduling specialty follow-ups. SOL could also improve by scheduling wound care during weekends and holidays. After reviewing all aspects, the OIG rated this indicator as *adequate*.

Case Review Results

The OIG clinicians reviewed 371 provider, nursing, specialty, and hospital events that required the institution to generate appointments. In this indicator we identified 31 deficiencies, 14 of which were significant.⁹

Access to Clinic Providers

Despite a provider shortage, SOL performed well with access to providers. Compliance testing showed that chronic care follow-up visits occurred within the ordered time frames (MIT 1.001, 88%). When sick call nurses referred their patients to a provider, the patients were always seen on time (MIT 1.005, 100%). When providers ordered follow-ups for sick call conditions, patients were also always seen within the ordered time frame (MIT 1.006, 100%).

Case review clinicians evaluated 206 outpatient provider and nursing events that required provider follow-ups and identified five deficiencies, two of which were significant. These occurred in case 15 and in the following examples:

- In case 11, a provider requested a primary care provider (PCP) follow-up within 30 days for low blood count, an intestinal infection, and inflammatory bowel syndrome. The order was modified by a scheduler four times before the compliance date. The patient was seen 11 days past the original compliance date.

9. Access to care deficiencies occurred in cases 6, 11, 12, 15, 16, 17, 18, 20, 21, 22, 23, 26, 27, 28, 29, 30, 32, 39, 47, and 54. Significant deficiencies occurred in cases 16, 17, 20, 26, 27, 32, 39, 47, and 54.

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
**Proficient
(92%)**

- In case 17, a patient had uncontrolled diabetes. A provider requested a follow-up appointment in three weeks. The patient was scheduled 13 weeks later.
- In case 23, a provider ordered a PCP follow-up for knee pain in 90 days. Although the patient was scheduled within 30 days for an unrelated reason, the original appointment was not scheduled as ordered.

Access to Specialized Medical Housing Providers

SOL performed well in providing access to the CTC. Compliance inspectors found that providers performed admission histories and physicals timely (MIT 13.002, 100%). However, compliance inspectors identified a problem with progress note intervals (MIT 13.003, 50%). Case review clinicians did not find any deficiencies related to access to CTC providers. Please see the **Specialized Medical Housing** indicator for further discussion.

Access to Clinic Nurses

Compliance testing showed that nurses always reviewed sick call requests the same day they collected them (MIT 1.003, 100%). Nurses regularly saw their patients with sick call symptoms within one business day (MIT 1.004, 97%). Case review clinicians identified 10 deficiencies in access to nursing care, eight of which were significant.¹⁰ These deficiencies occurred in cases 18, 39, 47, 54, and in the following:

- In case 20, a diabetic patient with a bone infection already had an amputation of one of his big toes. A provider ordered daily wound care; however, the wound care was not scheduled consistently. The first appointment was not scheduled for five days and on several occasions the patient was not scheduled on weekends.

This is further discussed under the indicator for **Nursing Performance**.

Access to Specialty Services

Compliance testing showed great specialty access for high priority (MIT 14.001, 100%), medium priority (MIT 14.004, 87%), and routine priority appointments (MIT 14.007, 100%). When specialists requested follow-up appointments, the institution regularly scheduled the requested appointments timely (MIT 14.003, 91%; MIT 14.006, 100%; and MIT 14.009, 100%).

However, OIG case review clinicians found a pattern of delayed specialty access. SOL exhibited delays in cases 20, 28, 29, and 30. Some delays were

¹⁰ Deficiencies occurred in 18, 20, 39, 47 and 54. Significant deficiencies occurred in 20, 39, 47, and 54.

caused by discrepancies in the way orders were entered in the electronic health record system (EHRS).¹¹ This occurred in the following cases:

- In case 22, a provider reviewed an ophthalmologist's recommendation to follow up in three months. While the provider wrote in the comments for the patient to follow up in three months, the provider placed the order with a compliance date of 118 days. As a result, the patient was scheduled with the specialist 100 days later, thus not following the ophthalmologist's recommendation.
- In case 23, a provider requested a two-month endocrinology follow-up in the comment section of the request for service, but ordered a compliance date of 90 days. The patient was scheduled to follow up in 90 days instead of two months.

SOL did not always reconcile specialty appointments after a patient returned from a hospitalization. This also occurred in Cycle 5. OIG case reviewers identified this issue in the following cases:

- In case 26, a patient did not have his pending ophthalmology imaging appointment properly reconciled after a return from the hospital. This caused a two-month delay of this test.
- In case 27, a patient had a pending ophthalmology follow-up appointment that was not reconciled by the institution upon the patient's return from the hospital. As a result, the patient's glaucoma follow-up did not occur during the review period.

Provider Follow-Up After Specialty Service

During the Cycle 6 review period, SOL generally arranged for provider follow-ups after specialty consultations. Compliance testing results reflected this (MIT 1.008, 81%). Case review clinicians only found the following deficiency:

- In case 16, an out-to-medical nurse documented that a patient with high-grade prostate cancer would be seen by the PCP within 14 days of visiting a urologist. However, the appointment was not made. It is unclear from the documentation where the breakdown occurred. The patient was incidentally seen 17 days later because he had a scheduled PCP follow-up after he was sent to an outside emergency department for chest pain.

Follow-Up After Hospitalization

After returning from an off-site hospital, patients were often scheduled with a follow-up appointment with a provider. Compliance testing

11. There are set appointment priorities: high (must be scheduled within 14 days), medium (15-45 days), and routine (46-90 days). The provider must choose one of these set priorities and enter a compliance date. In the comment section, the provider enters scheduling instructions for earlier appointments. The appointments were scheduled by priority compliance date and not per provider scheduling instructions.

results were good (MIT 1.007, 84%) and case review results showed only one deficiency:

- In case 6, a nurse ordered follow-up with the PCP within three business days of an emergency department visit for a drug overdose. However, the scheduler modified the order several times, beyond the time frame originally ordered by the nurse. Although the patient was eventually seen, the rescheduling was below medical standards.

More details are available in the **Transfers** indicator.

Follow-Up After Urgent or Emergent Care

SOL providers saw patients promptly after they received urgent or emergent care in the TTA. Out of 42 TTA events reviewed, OIG clinicians found only one deficiency. In this case, TTA staff did not order a follow-up appointment with the primary provider. Please see the **Emergency Services** indicator for additional discussion on urgent and emergent patient care.

Follow-Up After Transferring Into the Institution

Compliance testing showed that patients who were referred from another departmental institution were timely seen by their provider 79 percent of the time (MIT 1.002). In two cases, appointments with a provider were late by one day and in two other cases, appointments with a provider were late by two to three days. OIG clinicians identified one significant deficiency, which follows:

- In case 32, a high-risk patient with a history of heart disease and stroke was transferred to SOL. The patient had a PCP appointment ordered within seven days, but the patient was not seen until 16 days after his arrival at SOL.

Please see the **Transfers** indicator for additional details on transfer care.

Clinician On-Site Inspection

SOL managers reported that they have had provider and nursing shortages with unfilled vacancies for years. They also reported that one provider passed away near the beginning of the case review period. Later in the review period, two providers resigned and one provider retired. These departures reduced the availability of provider appointments, reduced patient care continuity, and increased the backlog of provider appointments.

In Cycle 5, many appointments were canceled and rescheduled due to provider unavailability. However, this was a rare occurrence in Cycle 6.

Staff at SOL advised that due to staffing vacancies and the resulting backlog of appointments, access to care was adjusted so that emergent

sick calls were directed to the TTA and all other calls were directed to clinic lines the following business day.

Recommendations

- The department should consider how to address the disconnect between the standard order time frame and the time frame providers request in their requests for services.
- Medical leadership should remind providers to reconcile pending specialty consultations after a patient returns from the hospital.
- Scheduling supervisors should ensure that daily wound care appointments occur on weekends and holidays as ordered.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	22	3	0	88%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	19	5	1	79%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	29	1	0	97%
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) *	14	0	16	100%
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) *	6	0	24	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) *	21	4	0	84%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	35	8	2	81%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
Overall percentage (MIT 1): 92%				

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

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

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

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	2	2	6	50%
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) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	10	1	4	91%
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) *	13	2	0	87%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	4	0	11	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	6	0	9	100%

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

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

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

Overall
Rating
Inadequate

Case Review
Rating
Adequate

Compliance
Score
**Inadequate
(56%)**

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's ability to complete radiology, laboratory, and pathology tests on time. The inspectors determined whether the institution properly retrieved test results and whether providers reviewed the results correctly. In addition, in Cycle 6, the OIG examined the institution's ability to complete and review *stat* (immediate) laboratory tests on time.

Results Overview

SOL performed well in routine diagnostic tests, but faltered in other areas. SOL did not process and timely notify the PCP of *stat* laboratory results, which are critical in the care of urgent or emergent patients. There was also a pattern of providers not signing diagnostic results. This may have coincided with provider departures due to retirement and separation from the institution. SOL's overall poor compliance performance weighed heavily in the OIG's rating for this indicator, which was *inadequate*.

Case Review Results

OIG clinicians reviewed 182 diagnostic events and found 14 deficiencies, of which five were significant. Of those 14 deficiencies, nine were related to health information management and four pertained to the completion of diagnostic tests. For health information management, case review clinicians considered test reports that were never retrieved or reviewed to be as problematic as tests that were never performed.

Test Completion

SOL performed excellently in completing radiology services within required time frames (MIT 2.001, 100%), but less so with completing laboratory services (MIT 2.004, 70%) within required time frames. Case review analysis demonstrated good performance in diagnostics, with minor deficiencies. The following examples were identified:

- In case 12, a provider ordered that X-rays of a patient's shoulder and clavicle be completed within two weeks, but they were not completed until two months later.
- In case 21, a provider ordered laboratory tests be performed on a specific date; however, laboratory personnel did not collect the specimen until 11 days after the order was to be performed.
- In case 28, requested laboratory services were not performed.

Compliance reviewers found that 40 percent of the *stat* laboratory tests were completed on time (MIT 2.007). Case reviewers, however, did not review any *stat* laboratory events.

Health Information

SOL staff retrieved laboratory and diagnostic results promptly and sent them to providers for review. Compliance testing showed that providers endorsed both radiology (MIT 2.002, 90%) and laboratory (MIT 2.005, 100%) results timely. Case reviewers found a pattern where the institution did not obtain provider signatures timely, which occurred in cases 19 and 27, and in the following examples:

- In case 12, the institution did not send a patient's shoulder X-ray results to the provider and did not obtain the provider's endorsement.
- In case 17, a patient had urine studies performed and the institution did not obtain the provider's endorsement timely. In the same case, the patient had an abnormal diabetes test result and the institution did not obtain the provider's endorsement in a timely manner.
- In case 28, a patient had an abdominal ultrasound on-site that was ordered by a headquarters provider for a pretransplant evaluation. The institution did not obtain the provider's endorsement of the ultrasound results.

Compliance testing showed that nurses did not timely notify providers of the results of stat laboratory tests (MIT 2.008, 0%). This is discussed further in the **Health Information Management** indicator. Case review analysis did not identify any stat laboratory deficiencies. SOL performed well in retrieving pathology results (MIT 2.010, 80%) within specified time frames, but not in reviewing them (MIT 2.011, 67%) within specified time frames.

Clinician On-Site Inspection

SOL laboratory staff explained how laboratory tests were performed, outlining the steps necessary for routine and stat orders. Routine laboratory tests were drawn in the morning. After 3:00 p.m. or on weekends, the patient went to the TTA for the laboratory draw. SOL staff reported they expect it to take four hours to obtain the results for stat laboratory tests. This time frame is consistent with statewide policy.

SOL staff confirmed there were no backlogs in performing laboratory tests. Since Cycle 5, SOL has implemented EHRS, which ensures that laboratory results are viewable by providers.

Our case reviewers found that one provider at SOL erroneously ordered a nuclear medicine stress test as a *radiology order* instead of a *specialty procedure*. As a result, this request was not routed to the appropriate staff to schedule the appointment. We interviewed radiology staff about the process for ordering diagnostic tests to clarify this particular nuclear medicine stress test order. The staff reported that this test would need to be ordered as a request for services order (specialty order). In addition, radiology staff reported that some providers requested testing dates in

the comment section of the EHRS order that did not match the standard order time frame in the EHRS.

Recommendations

- Medical leadership should access and review line providers' EHRS inboxes to ensure that staff providers timely review diagnostic results.
- The department should clarify whether it is the responsibility of specialty telehealth providers or the responsibility of the primary care provider to follow up with patients after specialty laboratory test results are received.
- Medical leadership should remind providers of which diagnostic studies require approval from utilization management.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	9	1	0	90%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	2	8	0	20%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	7	3	0	70%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
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%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	4	6	0	40%
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	0	10	0	0
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	9	1	0	90%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	8	2	0	80%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	6	3	1	67%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
Overall percentage (MIT 2): 56%				

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

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

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
(N/A)

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services (EMS) by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the quality of emergency medical responses, cardiopulmonary resuscitation (CPR), TTA care, provider performance, and nurse performance. We also evaluated the Emergency Medical Response Review Committee's (EMRRC's) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; we did not perform compliance testing for this indicator.

Results Overview

SOL nursing staff provided timely and appropriate emergency care. Staff readily recognized emergency situations, such as opioid overdoses, without delay. Providers made good decisions when evaluating patients.

However, OIG clinicians identified two areas needing improvement. Information for emergency responses was either missing or had inconsistencies, as set out further below. Nursing assessments were incomplete. Overall, the institution's emergency services were acceptable, resulting in an *adequate* rating for this indicator.

Case Review Results

Of the 20 cases our clinicians reviewed, which involved 42 urgent or emergent events, we found 46 emergency care deficiencies.¹² Of these 46 deficiencies, three were significant.¹³ These three significant deficiencies related to follow-up after evaluation in the TTA. In Cycle 5, SOL had a comparable number of deficiencies.

Emergency Medical Response

SOL performed well in emergency medical response. TTA nurses responded to all emergencies in the facility and, with the implementation of the revised emergency medical response policy, all health care and custody staff received training in emergency response. OIG case review clinicians reviewed 31 medical events that involved a first medical responder and identified lapses in nursing documentation and assessments. However, these documentation and assessment deficiencies did not affect the overall care of the patient.

- Incomplete nursing documentation of provider notification, the intravenous (IV) insertion site, EMS notification, medication

12. We reviewed emergency events in cases 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 19, 20, 22, 23, 24, 25, 26, 27, and 34. We found deficiencies in cases 1, 3, 4, 5, 6, 8, 9, 10, 20, 22, 23, 24, 25, 26, and 34.

13. Significant deficiencies were found in cases 25 and 26.

administration, and inconsistent documentation of the timeline of medical events were found in cases 5, 8, 10, and 25.

- Incomplete assessments were found in cases 3, 5, 10, 11, 20, 23, 24, and 25.

Cardiopulmonary Resuscitation Quality

SOL emergency staff performed well in situations that required resuscitation efforts. During emergencies, nursing staff assessed patients quickly and applied appropriate interventions. Staff immediately initiated CPR and recognized opioid overdoses; staff were able to successfully resuscitate five patients with timely Narcan (an opiate antidote) administration.

Provider Performance

SOL providers' performance was adequate in emergency care. In most TTA encounters, providers assessed patients appropriately and intervened with prompt treatment decisions. As in Cycle 5, OIG clinicians identified areas of improvement with documentation and clinical follow-up. Cases 3, 4, 8, 23, and the following showed lapses in documentation:

- In case 1, a provider did not document a TTA progress note when he saw a patient in the TTA and eventually transferred the patient to a hospital for further work-up.

Clinical follow-up is often necessary to ensure that patients are clinically improving after an emergency evaluation. Follow-up was lacking or late in case 26 and in the following case:

- In case 25, a provider did not schedule a follow-up with the primary care team after diagnosing a patient with a soft tissue infection and treating the patient with antibiotics in the TTA. Although this did not cause harm to the patient, it was below community standards.

Nursing Performance

Case reviewers found that TTA nurses frequently provided appropriate and timely interventions during emergencies. Although nurses often provided quality care in the TTA, OIG clinicians identified need for improvement in assessment, communication, and documentation. Such deficiencies were found in cases 3, 5, 11, 20, and in the following:

- In case 23, a patient arrived to the TTA with dizziness and low blood pressure. After receiving IV fluids, the patient's blood pressure was still below normal. A nurse did not recheck vital signs and reassess the patient prior to discharging the patient from the TTA.

- In case 24, a nurse performed an incomplete assessment of a right thigh skin infection. The nurse did not include the wound description, wound measurements, or presence of drainage.
- In case 25, a nurse did not complete an abdominal examination when a patient complained of nausea and dry heaving.

Timely and complete communication between the institution and community hospitals is necessary to ensure continuity of patient care. Our OIG clinicians identified a trend in which SOL nurses did not always communicate with community nursing staff about patients transferring out of SOL.¹⁴

Nursing Documentation

While performing case review testing, OIG clinicians noted that documentation for tasks and care provided during emergencies lacked thoroughness.¹⁵

- In cases 3, 11, and 23, nurses did not document IV insertion (site, catheter site) and medication administration.
- In cases 4, 5, 8, and 23, nurses did not document provider notification.
- In cases 4, 5, 10, and 24, first responder documentation was missing. Documentation should have included the EMS notifier, the EMS arrival and departure times, and the responder time. In addition, timelines reflected in the documentation should have been consistent.

Emergency Medical Response Review Committee

The EMRRC not only reviewed the quality, timeliness, and adequacy of all emergency medical responses; it also developed corrective action plans to improve the emergency medical response process.

OIG clinicians reviewed 10 EMRRC cases. The committee did not always recognize incomplete assessments, incomplete documentation of IV insertions, or incomplete notification to provider and emergency services.¹⁶ In addition, EMRRC did not always review emergency cases within the required time frame.

- Case 1 was not submitted for EMRRC review. The event occurred on July 28, 2019, when a patient complained of chest pain.
- In Case 34, EMRRC review did not occur timely. On July 22, 2019, a patient was sent to the hospital for chest pain and evaluation following a cerebral vascular accident. The EMRRC

14. Lack of documentation of hand-offs were identified in cases 1, 4, 5, 6, 23, 26, and 34.

15. Nursing documentation deficiencies were identified in cases 3, 4, 5, 8, 10, 11, 23, 24, and 34.

16. EMRRC reviews occurred in cases 1, 3, 4, 5, 6, 8, 10, 20, 24, and 34. Deficiencies were found in cases 3, 4, 5, 6, 8, 10, and 20.

review occurred on August 29, 2019, which was beyond the time frame required to complete the review.

Clinician On-Site Inspection

OIG case review clinicians interviewed TTA nursing staff and supervisors. The TTA is currently a two-bed unit, but expansion to a four-bed unit is underway. A dedicated provider is assigned to the TTA Monday through Thursday during normal operating hours; an on-call provider covers the TTA after hours, on Fridays, and on weekends.

Per the SOL nursing staff, TTA staff treats an average of one to two opiate overdose patients and one stabbing victim per week. Nursing and custody staff have a good rapport and both staff participate in emergencies.

Nursing staff reported their appreciation for the collaboration between the TTA and yard staff during emergency responses. Nursing supervisors perform chart reviews and audits to determine training opportunities for their staff. Before the OIG clinician on-site visit, the TTA supervisor had already identified emergency response documentation as an area that needed improvement. The nurse instructor reported that a position was recently allocated to provide more training opportunities. For the trainings, nursing supervisors offered scenarios to improve specific assessment and documentation skills. They also conducted quarterly emergency mock drills and an annual mass casualty drill.

Nursing staff and supervisors mentioned that the local institution's administration was approachable and supportive.

Recommendations

- Medical leadership should remind providers to document their emergency encounters.
- Nursing leadership should remind nurses to thoroughly complete and accurately document all medical assessments.

Overall
Rating
Proficient

Case Review
Rating
Proficient

Compliance
Score
Adequate
(76%)

Health Information Management

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

Results Overview

SOL's improvement in health information management resulted in the delivery of quality medical care and an overall **proficient** rating for this indicator. Complete implementation of EHRs reduced human scanning errors, allowed diagnostic results to be directly reported, and simplified the retrieval of medical records. The institution retrieved hospital discharge records and specialty reports timely.

However, the OIG found that the handling of stat laboratory and pathology results could be improved. We also found that providers mislabeled patient appointment types on the electronic medical record, a deficiency that could be corrected with electronic medical record training. Case reviewers found that these deficiencies were rarely clinically significant. The health information department improved its performance from the last inspection despite significant staff reduction. In this indicator, the case reviewers and compliance team had different ratings. Taking all factors into account, the rating for this indicator was **proficient**.

Case Review Results

OIG clinicians reviewed 1,018 events and found 30 deficiencies related to this indicator. Of those 30 deficiencies, only four were significant.¹⁷ Compared to Cycle 5, SOL significantly reduced the number of deficiencies.

Hospital Discharge Reports

Both case review and compliance testing found that SOL managed hospital discharge information well. SOL staff retrieved and scanned hospital discharge records timely (MIT 4.003, 95%). The institution ensured that all discharge records included discharge summaries and that the primary care provider reviewed the records within five calendar days of a patient's discharge (MIT 4.005, 100%). OIG case review clinicians reviewed 20 off-site emergency department and hospital visits

17. Health Information Management deficiencies were found in cases 1, 3, 8, 9, 11, 12, 15, 17, 19, 20, 22, 27, 28, 29, 30 and 34. Significant deficiencies were identified in cases 12, 17, and 28.

and found a minor problem with the retrieval of the discharge summary in the following cases:

- In cases 3 and 8, a patient was transferred from one hospital to another and the institution did not obtain hospital records from the first hospital.

OIG case review clinicians' findings coincided with that of compliance testing in that SOL providers were punctual in reviewing and signing hospital discharge records. Please refer to the **Transfers** indicator for additional details regarding hospital discharge reports.

Specialty Reports

SOL improved its performance in specialty report retrieval from Cycle 5 for all priority levels: routine, medium, and high (MIT 4.002, 87%). OIG clinicians found that SOL had few deficiencies in retrieving, scanning, and signing specialty reports. The institution did not timely retrieve or scan dictated specialty reports in cases 15, 19, 29 and in the following:

- In case 20, the institution did not retrieve a dictated vascular surgeon specialty report.

SOL providers either did not sign or delayed signing specialty reports in cases 15, 22, 30 and in the following:

- In case 29, a provider did not sign an ENT (ear, nose, and throat) specialist report timely.

For additional details regarding SOL's specialty report processing, please refer to the **Specialty Services** indicator.

Diagnostic Reports

We reviewed 181 diagnostic reports and found isolated deficiencies. Laboratory results were signed late in cases 17, 19, and 27. Imaging tests were not retrieved or were endorsed late in cases 20 and in the following:

- In case 28, a patient with chronic kidney disease underwent evaluation for a kidney transplant. The patient had a liver ultrasound as part of the evaluation. However, the institution did not obtain the provider's endorsement of the ultrasound report.

Compliance testing showed that nurses did not timely notify the ordering provider after a stat laboratory result became available for review (MIT 2.008, 0%). Compliance testing also found that providers timely reviewed and signed pathology reports about two-thirds of the time (MIT 2.011, 67%). SOL providers did not send letters to their patients to notify them of pathology results (MIT 2.012, 0%). However, providers

discussed diagnostic pathology results with their patients at subsequent clinic appointments.

Urgent and Emergent Records

SOL providers and nurses generally recorded emergency care adequately, including off-site telephone encounters. The OIG identified one deficiency in which a provider did not document a progress note. At the on-site interview, the provider was aware of this and has taken steps to improve documentation.

Please refer to the **Emergency Services** indicator for additional information regarding emergency care documentation.

Scanning Performance

Case review testing revealed that SOL generally scanned documents timely and correctly. A few late or misfiled scans occurred in cases 1, 5, 28, 34 and in the following:

- In case 11, nursing staff performed an electrocardiogram. A provider endorsed it on the same day; however, it was scanned into the patient's electronic health record four days later.

Compliance testing revealed a low score for scanning, labeling and filing medical records properly (MIT 4.004, 0%). Upon analysis of these 24 compliance cases, we found that 21 were a result of a provider filing a patient visit as an *outpatient progress note* instead of an *inpatient progress note*. One provider was responsible for 15 of these cases. However, this provider had already retired from the institution before the on-site inspection.

Clinician On-Site Inspection

At the on-site inspection, OIG case reviewers interviewed medical managers, health information management supervisors, providers, nurses, and ancillary staff. The health information department reported that they provided in-service trainings and attended providers' meetings. Health information management supervisors expressed concern about staff limitations, particularly with the increased volume of patients to more than 140 percent over capacity (per the chief medical executive). With the implementation of the EHRS, the health information management team was reduced from a staff of 13 to a staff of four.

Additionally, we observed providers' and staff's review of patients' hospitalizations, transfers, and follow-up appointments during huddles. Providers and staff reported no difficulties with any specialty vendors' reports. Health information management completed occasional periodic reviews to ensure that providers were signing and endorsing reports in a timely manner.

Recommendations

We have no specific recommendations for this indicator.

Compliance Testing Results

Table 9. 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	0	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	87%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	19	1	5	95%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	0	24	0	0
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	25	0	0	100%
Overall percentage (MIT 4): 76%				

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

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

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	0	10	0	0
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	6	3	1	67%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	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) *	13	2	0	87%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	9	6	0	60%
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) *	11	4	0	73%

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

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

Health Care Environment

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' ability to maintain 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, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians typically do not rate this indicator.

Results Overview

For this indicator, SOL's performance improved compared to its performance in Cycle 5. Clinic environments were sufficiently conducive for medical care, clinics followed protocols for managing and storing bulk medical supplies, and clinical health care areas were appropriately disinfected and cleaned.

However, there was room for improvement in some aspects of SOL's health care environment. For example, the emergency medical response bags that we examined were not consistently sealed. A few clinics lacked core medical equipment and supplies. Lastly, SOL staff did not consistently wash their hands when examining patients or when applying gloves. Overall, the rating for this indicator was *adequate*.

Compliance Testing Results

Outdoor Waiting Areas

With the new Health Care Facility Improvement Program (HCFIP) construction of SOL clinics, there were no waiting areas that required patients to be outdoors. *(Indicator narrative and photographs continue on the next page.)*

Overall
Rating
Adequate

Case Review
Rating
(N/A)

Compliance
Score
Adequate
(76%)



Photo 1. Indoor patient waiting area (photographed on September 10, 2019).

Indoor Waiting Areas

We inspected indoor waiting areas. Health care custody staff reported that existing waiting areas had sufficient seating capacity (Photo 1, left).

In addition to the waiting area, there were two adjacent rooms for patient overflow (Photo 2, right). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.



Photo 2. Additional indoor patient waiting area (photographed on September 10, 2019).

Clinic Environment

All nine of the clinic environments were conducive for medical care (MIT 5.109, 100%); they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace.

Of the nine clinics we observed, seven contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 78%). The remaining two clinics had examination rooms that lacked visual privacy for conducting patient examinations (Photo 3, below).



Photo 3. Examination room lacking visual privacy (photographed on September 10, 2019).

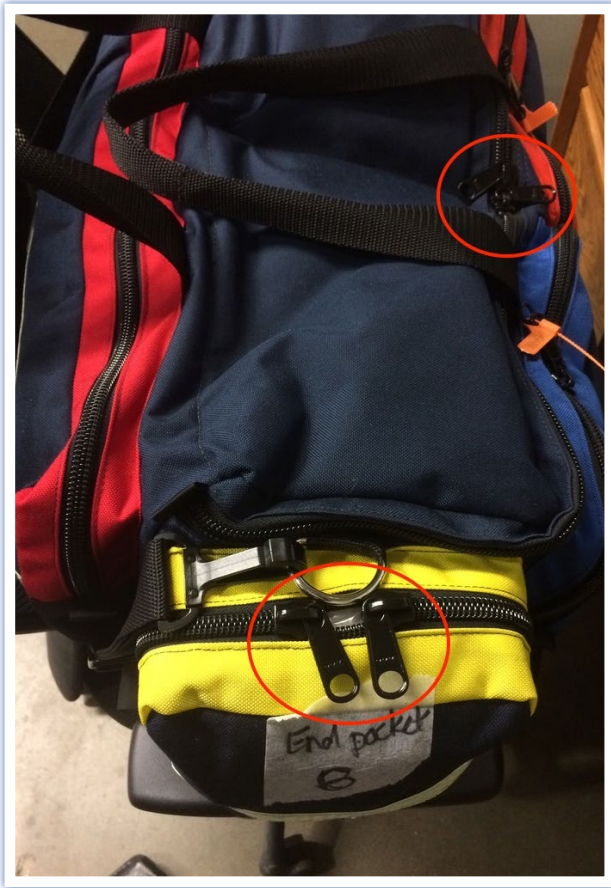


Photo 4. EMRB compartments left unsealed (photographed on September 13, 2019).

Clinic Supplies

All nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, 100%).

Six of the nine clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 67%). The remaining three clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. Such deficiencies included a lubricating jelly missing from an examination room, an examination table missing from an examination room, and a current calibration sticker missing from a weighing scale.

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked if staff inspected the bags daily and inventoried them monthly. None of the five EMRBs passed our test (MIT 5.111, 0%). Staff failed to ensure that all EMRB compartments were sealed and intact (Photo 4, left). Staff reported that their nursing supervisor instructed them to leave the EMRB compartments unsealed to perform daily equipment inspections. In addition, the emergency crash cart did not contain the minimum medical supply inventory levels.

Medical Supply Management

The institution scored 100 percent on our testing of its medical supply management (MIT 5.106). Institution staff proficiently stored clinic medical supplies in the medical supply storage areas outside the clinics (e.g., warehouse, Conex containers, etc.).

According to the chief executive officer (CEO), warehouse staff perform inventory and maintain the minimum medical supply inventory level for each clinic on a weekly basis. For additional or special medical supplies, nursing supervisors coordinate with the warehouse manager, and medical supplies are delivered to the clinic on the same day. Furthermore, health care managers expressed no concerns about the medical supply chain or their communication process with the existing system in place.

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized all nine clinics (MIT 5.101, 100%).

Staff in four of eight applicable clinics properly sterilized or disinfected medical equipment (MIT 5.102, 50%). The remaining four clinics had one or more of the following deficiencies: staff did not immediately remove and replace the examination table paper in between patient encounters; and when describing their daily start-up protocol, staff relied on health care facilities maintenance porters to disinfect the examination table before the start of their shift.

We found operating sinks and hand hygiene supplies in the examination rooms in eight of nine clinics (MIT 5.103, 89%). In one clinic, the patient restroom lacked antiseptic soap and disposable towels.

We observed patient encounters in six clinics. Clinicians followed good hand hygiene practices in three clinics (MIT 5.104, 50%). In three clinics, clinical health care staff failed to wash their hands before or after examining their patients, or before performing an injection.

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

Physical Infrastructure

At the time of inspection, SOL was renovating and adding clinic spaces to two medical clinics. These projects began in 2015, and health care managers estimated completion of the projects by early 2021. According to the institution's CEO, the renovation and expansion of the clinics will be delayed due to the following issues: the pending installation of fire sprinklers by a state fire marshal certified installer; the delayed procurement of fire-rated security glazing, doors, and windows due to construction market conditions; and the pending completion of the Americans With Disabilities Act compliant cell design. However, the CEO did not believe the delay would negatively impact patient care (MIT 5.999).

Recommendations

- Medical leadership should ensure that emergency medical response bags are regularly sealed and inventoried.
- Medical leadership should ensure that clinic common areas and examination rooms contain essential core medical equipment and supplies.
- Medical staff should be reminded to follow universal hand hygiene precautions. Implementing random spot checks may help with compliance.

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	9	0	0	100%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	4	4	1	50%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	1	0	89%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	3	3	50%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	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)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	9	0	0	100%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	6	3	0	67%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	7	2	0	78%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	0	5	4	0
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
Overall percentage (MIT 5): 76%				

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

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

Transfers

In this indicator, OIG inspectors examined the transfer process for patients who transferred into the institution as well as for those who transferred to other institutions. For newly arrived patients, OIG inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, our inspectors checked whether staff reviewed patient medical records and determined patients' need for medical holds. They also assessed whether staff transferred patients with their medical equipment and gave correct medications to patients before they transferred out. In addition, our inspectors evaluated staff's ability to communicate vital health information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; OIG inspectors confirmed whether staff sent complete medication transfer packages to the receiving institution. 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.

Results Overview

The OIG evaluated SOL's transfer process through case reviews, compliance testing, and on-site inspections. SOL revealed multiple opportunities for improvement for this indicator. For patients transferring into the institution, we found incomplete initial health screenings. For patients arriving on a layover (temporary stay en route to another institution), we found loss of continuity for chronic care medication and failure to reconcile preapproved specialty appointments. For patients transferring out of the institution, we found incomplete assessments, missing vital signs, and poor documentation of keep-on-person (KOP) medication availability upon transfer.

For patients returning from an off-site hospital, our inspectors identified incomplete assessments, poor communication of hospital recommendations to the provider, and incomplete reconciliation of medication and follow-up orders.

Considering the whole transfer process, including the afore-mentioned transfer-in concerns and hospital discharge problems, the rating for this indicator was *inadequate*.

Case Review Results

OIG clinicians reviewed 26 events in 25 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. Of the 26 events, case reviewers identified 15 deficiencies. While there were fewer deficiencies as compared to Cycle 5, OIG case reviewers identified deficiencies in nursing

Overall
Rating
Inadequate

Case Review
Rating
Inadequate

Compliance
Score
**Inadequate
(67%)**

assessments, medication documentation, and specialty referrals, which affected patients' care during the transfer processes.

Transfers In

Compliance testing showed that nurses did not adequately complete initial health screenings (MIT 6.001, 0%). They did not ask about fatigue in TB screenings, did not obtain more information when patients had a history of mental illness, and did not check blood sugars when patients were diabetic. Case review clinicians found the same problem with incomplete initial assessments. In all three applicable cases, we found deficiencies in assessment and documentation:

- In cases 31 and 33, an R&R nurse did not perform a finger stick blood sugar check and assess for cocci risk factors on a diabetic patient.
- In case 32, an R&R nurse did not recheck the blood pressure or assess a hypertensive patient with poor blood pressure control for medication compliance.

Providers saw newly arrived patients at an acceptable rate (MIT 1.002, 79%). Case review testing found room for improvements in this area:

- In case 32, an R&R nurse requested a PCP initial appointment within seven days for a high-risk, uncontrolled, hypertensive patient; however, the appointment did not occur within the requested time frame. The patient was subsequently sent to the hospital for dizziness and hypertension, which was potentially preventable if the appointment had occurred as requested.

Compliance testing showed SOL had difficulty scheduling timely specialty appointments for patients who transferred into the institution with preapproved specialty referrals (MIT 14.010, 40%). OIG case review clinicians found that most problems were due to reconciliation errors upon a patient's arrival to the facility.¹⁸ During the on-site visit, SOL staff were unsure who was responsible for completing this task. OIG clinicians received four different answers from four different staff members.

Medication continuity for transfer-in patients was fair (MIT 6.003, 73%). Moreover, medication continuity for patients on a layover was poor (MIT 7.006, 40%). With closer review of these compliance samples, we found the problems were related to KOP medications. SOL lacked consistent documentation for layover patients receiving their KOP medication.¹⁹

18. Transfer reconciliation is the institution's process of reviewing and ordering transfer medications, tests, and referral appointments. Statewide policy does not delineate responsibilities for reconciliation, only that this process must occur. If the process is seamless, then there is no disruption of medical care with the transfer. EHRs designate specific ordering qualifications for nurses and providers, which is specific to each, but not shared.

19. Per CCHCS DOM (Department Operations Manual) Chapter 3, Article 2, KOP medications shall be documented in the medication administration record or on a temporary record used for patients en-route or on layovers.

On the other hand, directly observed therapy medications were given without delay. When patients transferred from one yard to another, they continued their medications without interruption most of the time (MIT 7.005, 84%).

Transfers Out

Compliance testing for medication transfer packages for patients transferring out of SOL was excellent (MIT 6.101, 100%). However, our clinicians identified deficiencies on nursing assessments that included missing vital signs, failure to notify the receiving facility of specialty appointments, and a lack of nursing evaluation prior to transfer.

- In case 35, a nurse did not obtain vital signs on a patient prior to transfer and did not document that the patient would have nitroglycerin tablets (medication for chest pain) with him when he left the institution.
- In case 36, a nurse did not perform a face-to-face evaluation 24 hours prior to transfer to ensure that a patient had all required durable medical equipment.
- In case 37, a nurse did not complete a nursing assessment and obtain vital signs on a patient. In addition, the nurse did not document whether the patient transferred with durable medical equipment, whether the receiving facility was notified of pending specialty appointments, and whether the patient transferred with a five-day supply of medication.

Hospitalizations

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

Compliance testing showed good access to providers after hospital and emergency room visits (MIT 1.007, 84%), prompt scanning of discharge documents (MIT 4.003, 95%), and timely provider review of every hospital or emergency department encounter (MIT 4.005, 100%). However, SOL showed room for improvement in ensuring the continuity of recommended medications (MIT 7.003, 48%). In two of the samples reviewed by the compliance team, a nurse documented that a medication was not given to a patient returning from a hospitalization because

the patient did not request a refill.²⁰ This is discussed further in the **Medication Management** indicator.

OIG clinicians reviewed 19 events in which a patient returned from the emergency department or was discharged from a hospital. Case reviewers identified seven deficiencies.²¹ Most were nursing deficiencies that included incomplete assessment of wounds, poor communication with providers, and failure to comply with recommended discharge orders.

- In case 6, a patient returned from an emergency department visit for an opioid overdose. The out-to-medical nurse requested a provider follow-up within five days. Instead, the provider follow-up occurred 12 days later.
- In cases 6 and 8, a nurse did not document notifying the provider when a patient returned from the hospital. This did not meet nursing standards.
- In cases 3 and 20, nurses did not assess wounds nor document pertinent examinations.

Clinician On-Site Inspection

Our clinicians met with the nurse managers at SOL to discuss case review findings. The R&R nursing staff reported that SOL processes on average 60 to 100 patients per week. The R&R nurse was knowledgeable about the screening process for transfers in and transfers out and of the importance of communicating with Central Fill Pharmacy and the care management teams regarding continuity of care for medications and follow-ups.

Our case review clinicians and SOL nursing managers also discussed deficiencies in the documentation of identified KOP medications, especially for patients arriving to the institution on a layover. We observed that the R&R clinic did not have a medication storage area to ensure that medication is available for patients who arrive without their medication. However, R&R nurses have access to a medication storage unit, which serves the same function.

We also discussed the process of reconciling preapproved specialty orders for new arrivals and found there was confusion among physicians and nurses in utilization management, specialty services, TTA, and R&R about who was responsible for the reconciliation. Nursing leadership acknowledged that specialty orders were not reconciled timely and resolved to place new staff in specialty services and provide training to ensure the continuity of specialty care.

20. In this medication process, medications are refilled when a patient initiates a request to fill the medication, as compared to when the pharmacy automatically refills the medication (auto refill). This illustrates that the refill request process can lead to unintended consequences—medications ordered upon return from the hospital were not given because the patient did not request a refill.

21. Deficiencies were identified in cases 3, 6, 8, and 20.

Recommendations

- Nursing leadership should monitor the performance of R&R staff to ensure they thoroughly complete nursing assessments, perform appropriate nursing interventions, and document the continuity of chronic care medication.
- The department should clarify staff responsibilities of reconciling preapproved specialty orders and ensuring medication continuity.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	0	25	0	0
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	24	1	0	96%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	8	3	14	73%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	4	0	1	100%
Overall percentage (MIT 6): 67%				

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

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

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	19	5	1	79%
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) *	21	4	0	84%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	19	1	5	95%
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) *	25	0	0	100%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	12	13	0	48%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	21	4	0	84%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	4	6	0	40%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	8	12	0	40%

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

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

Medication Management

In this indicator, OIG inspectors evaluated the institution's ability to administer prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered it to the patient. In addition to examining medication administration, compliance inspectors tested many other processes, including medication handling, medication storage, error reporting, and other pharmacy processes.

Results Overview

SOL had mixed results. SOL staff ensured that patients received their newly prescribed medications and existing medications upon transferring into the institution. However, we identified deficiencies in hospital discharge medications, chronic care medications, and KOP medications. In addition, there were poor compliance rates for providing specialized medical housing medications and transfer medications. The rating for this indicator was *inadequate*.

Case Review Results

OIG clinicians reviewed 165 medication events in 30 cases related to medication management and found 39 deficiencies, 10 of which were significant. There were more deficiencies in this area than during Cycle 5. Lapses occurred in medication continuity and in the documentation of medication administration, which made it unclear whether patients received their medication. Therefore, although the compliance review reflected an *adequate* rating, when reviewed holistically, the significant deficiencies and lapses in medication continuity and the documentation of medication administration led to OIG clinicians' overall rating of this indicator as *inadequate*.

New Medication Prescriptions

SOL performed acceptably in managing new medication prescriptions. Case review clinicians did not identify any problems relating to new prescriptions. Compliance testing showed that patients often received new order medications within the required time frames (MIT 7.002, 76%).

Chronic Medication Continuity

During this review period, SOL performed poorly in ensuring continuity of chronic care medications. Compliance testing revealed poor continuity (MIT 7.001, 26%). Due to a large quantity of returned medications, the pharmacy initiated a *request refill* practice, in which medications were not

Overall
Rating
Inadequate

Case Review
Rating
Inadequate

Compliance
Score
**Adequate
(79%)**

automatically refilled.²² This brought to light deficiencies as shown in cases 21, 34, and in the following:

- In case 11, a patient had inflammatory bowel disease, which can affect absorption of minerals and nutrients. As a result, the patient had low calcium levels and needed calcium and vitamin D supplementation. He did not receive this medication for five months.
- In Case 22, a patient did not get his glaucoma eye drops because he did not request a medication refill.
- In Case 24, a patient with advanced liver disease requested a refill of his lactulose.²³ The pharmacy reported that the medication was dispensed; however, the medication administration record did not show the patient had received it.

Case review clinicians also found gaps in the continuity of patients' chronic medications. This occurred in cases 7, 9, 14, 21, and in the following:

- In case 25, the institution did not ensure that a patient regularly received his aspirin, atorvastatin, and lisinopril.
- In case 28, a hypertensive patient did not receive his hydralazine for five months.²⁴

Hospital Discharge Medications

SOL did not ensure that patients received their recommended medications when they returned from an off-site hospitalization or emergency room visit. Compliance testing results revealed 48 percent compliance in this area (MIT 7.003). The case review analysis revealed two cases, described below, in which patients did not receive their medications after being discharged from a hospital:

- In case 8, a patient was discharged from the hospital with recommendations for three medications. These medications were not given timely.²⁵
- In case 24, when a patient was discharged from the hospital, the patient's primary care provider and an out-to-medical

22. In the request refill practice, the patient needs to request the medication refill. If the patient does not request a refill, the medication is not dispensed. This policy applies to medications such as supplements and eye drops.

23. Lactulose is a medication that reduces mental confusion in patients who have advanced liver disease.

24. Hydralazine is a blood pressure medication.

25. The three late medications were amiodarone (antiarrhythmic medication, loading dose of 400 mg for 10 days and then 200 mg daily), apixaban (blood thinner), and carvedilol (blood pressure medication that treats irregular heart rhythms).

return nurse did not reconcile the patient's medication, and the medication was given between one and three weeks late.²⁶

Specialized Medical Housing Medications

Compliance testing revealed problems with medication orders, medication availability, and the administration of medication to patients within the required time frame (MIT 13.004, 60%). However, case review clinicians identified only one deficiency in this area. In case 3, a nurse took a telephone order from the provider on-call and did not document a medication dose. When the pharmacist corrected this error, the start date was delayed by three days.

Transfer Medications

OIG compliance testing found the continuity of medications upon a new patient's arrival from another institution to be fair (MIT 6.003, 73%). The continuity of yard-to-yard transfer medications was better, with a score of 84 percent (MIT 7.005). However, patients on a layover during their transfer from another institution received their medications without interruption less than half the time (MIT 7.006, 40%).

However, SOL improved its process for outgoing transfers. The institution performed well in providing transfer packages that contained all required medications and documents to patients transferring out of the institution (MIT 6.101, 100%). According to our case review analysis, SOL performed well in processing transfer medications.

Medication Administration

SOL exhibited multiple deficiencies in medication administration. Every 30 days, EHRS automatically alerts medical nurses of an administrative task relating to chronic medications and requires that nurses document distribution of such medications. However, in cases 3, 8, 22, 25, and 26, we were unable to determine whether medications were distributed to patients.

Compliance testing revealed good TB medication continuity (MIT 9.001, 100%) but poor TB medication monitoring (MIT 9.002, 56%).

Clinician On-Site Inspection

OIG inspectors met with the pharmacist in charge (PIC) and nursing supervisors to discuss pharmacy processes and questions that arose from our case review analysis. At the time of the inspection, the PIC had been in her position for about one month.

26. The patient's medications were furosemide (medication to treat liver disease complication), lactulose (medication to treat liver disease complication), spironolactone (medication to treat liver disease complication), levothyroxine (medication for low thyroid levels), Nasacort (medication for nasal allergies), and ranitidine (medication for acid reflux).

The PIC explained that the *request refill* practice had several advantages: it reduces waste and requires patients to notify staff when they need medications, allowing them to practice responsibility for their own health. The PIC explained that this practice did not apply to chronic care medications, such as those used to treat hypertension or diabetes.²⁷ However, we found that some providers were unaware they were able to override the *request refill* practice. *Auto refill* medications are usually dispensed and given every 30 days.

OIG clinicians observed the process for ensuring intra-facility medication continuity in all yards. SOL had a process for ensuring the continuity of KOP medications, which involved keeping records in a binder in the medication rooms. However, the documentation was not available in the EHRS.

Additionally, OIG inspectors noted that pill line staff intermittently attended morning huddles, which resulted in limited information sharing within the huddle regarding patient compliance and refusals. Staff at the pill lines advised us that some reasons for missing the huddles included low staff availability, slow medication lines, and difficulty getting patients released from certain housing units.

Pill line nurses had an organized process for delivering KOP medications. Pill lines had little backlog of medications awaiting pick-up by patients. OIG clinicians were advised that if patients refused KOP medications, they were required to sign a refusal form at the pill line and the nurses would message the providers.

Neither lockdowns nor EHRS downtime impacted medication administration. Staff at SOL understood that medication administration must continue during a lockdown. Furthermore, in the event that EHRS was not operational, nurses understood the “downtime procedures,” which required charting medical administration records on paper.

Recommendations

- Pharmacists should contact the provider when they consider changing prescriptions to *request refill*.
- Nursing leadership should remind medication nurses to ensure accurate medical administration record documentation.
- Out-to-medical nurses should receive refresher training to reconcile all medications upon a patient’s return to the institution.
- Institutional leadership should remind providers to reconcile medications at every appointment.
- Nursing leadership should remind nursing staff that at least one pill line staff member should attend daily huddles.

27. The pharmacists on-site determined which ordered medications were to be converted to request refill. She reported that the providers could override this by noting in the comments section of the medication order that the medication should be administered as originally intended, and not changed.

- R&R staff should undergo additional training on completing KOP medication documentation for layover patients in the administrative segregation unit.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in four of seven clinic and medication line locations (MIT 7.101, 57%). In three locations, we found one or more of the following deficiencies: Narcotic inventory was not performed by two licensed staff, nurses did not verify the proper destruction of controlled substances, nurses did not record the administration time of controlled substances, and nurses did not mention the appropriate process for reporting narcotic medication discrepancies.

The institution appropriately stored and secured nonnarcotic medications in all seven clinic and medication line locations (MIT 7.102, 100%).

Staff kept medications protected from physical, chemical, and temperature contamination in six of the seven clinic and medication line locations (MIT 7.103, 86%). In one location, staff did not separately store germicidal wipes and medications.

Staff correctly stored unexpired medications in five of the seven medication line locations (MIT 7.104, 71%). In two locations, medication nurses failed to initial or label multi-use medication as required by California Correctional Health Care Services policy.

Nurses exercised proper hand hygiene and contamination control protocols in all six applicable medication line locations (MIT 7.105, 100%).

Staff in five of six medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 83%). In one location, staff could not explain the process for reconciling new medications received from the pharmacy with the physicians' orders.

Staff in four of six medication preparation and administration areas demonstrated appropriate administrative controls and protocols during medication administration (MIT 7.107, 67%). In two clinics, nurses could not describe the medication error reporting process.

Pharmacy Protocols

SOL followed general security, organization, and cleanliness protocols in its pharmacy. In addition, the pharmacy properly stored nonrefrigerated

and refrigerated medications (MIT 7.108, MIT 7.109, and MIT 7.110, 100%).

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

We examined 25 medication error reports and found that the PIC timely and correctly processed all 25 reports (MIT 7.112, 100%).

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors 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. The OIG did not find any applicable medication errors at SOL (MIT 7.998).

The OIG interviewed 10 patients in the administrative segregation unit to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. One patient indicated that custody staff took his inhaler along with his property. We promptly notified SOL's CEO of the concern, and health care management immediately reissued the patient's replacement inhaler (MIT 7.999).

Table 14. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	5	14	6	26%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	16	5	0	76%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	12	13	0	48%
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) *	21	4	0	84%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	4	6	0	40%
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)	4	3	3	57%
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)	7	0	3	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	6	1	3	86%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	5	2	3	71%
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)	6	0	4	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when <i>preparing</i> medications for patients? (7.106)	5	1	4	83%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when <i>administering</i> medications to patients? (7.107)	4	2	4	67%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	25	0	0	100%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
Overall percentage (MIT 7): 79%				

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

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

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	8	3	14	73%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	4	0	1	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	18	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	10	8	0	56%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	6	4	0	60%

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

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

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. OIG case review clinicians do not rate this indicator.

Overall
Rating
Inadequate

Case Review
Rating
(N/A)

Compliance
Score
Inadequate
(70%)

Compliance Testing Results

Recommendations

We have no specific recommendations for this indicator.

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	18	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	10	8	0	56%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	3	22	0	12%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 50 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	24	1	0	96%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	8	6	11	57%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
Overall percentage (MIT 9): 70%				

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

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

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
(N/A)

Nursing Performance

In this indicator, OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses, licensed vocational nurses, psychiatric technicians, and certified nursing assistants. Our clinicians evaluated nurses' ability to make timely and appropriate assessments and interventions. We also evaluated the accuracy and thoroughness of nurses' documentation. Clinicians reviewed nursing performance in many clinical settings and processes, including sick calls, 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 did not perform compliance testing for this indicator.

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

Results Overview

SOL nurses provided good care overall. Generally, nursing assessments were prompt and appropriate in outpatient, emergency or specialty housing units. We found that training and interdepartmental collaboration can be improved in the areas of nursing assessment and documentation, medication management, and transfer-in processes. The rating for this indicator was *adequate*.

Case Review Results

We reviewed 265 nursing encounters in 55 cases. Of the nursing encounters we reviewed, 149 were in the outpatient setting. We identified 103 deficiencies in nursing performance, 17 of which were significant.²⁸ Cycle 5 had a similar number of deficiencies.

Nursing Assessment

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interview) and objective (observation and examination) elements.

SOL nurses generally completed appropriate assessments. Specialized medical housing nurses completed admission assessments timely, and frequently performed good assessments throughout patients' stay in the CTC. However, TTA, R&R, and clinic nurses occasionally did not perform complete assessments as described in the following cases:

28. Significant nursing deficiencies occurred in cases 10, 11, 20, 21, 22, 24, 26, 43, 45, 49, 54, and 56.

- In case 22, a patient complained of bloodlike mucus and loss of vision. The nurse did not complete a full assessment and did not notify the provider about the loss of vision.
- In case 24, a nurse did not complete an assessment of a skin infection on a patient's right leg. In a separate event, the nurse did not obtain vital signs or complete an assessment for this patient when he complained of a slow heart rate.
- In case 26, a patient had a nurse follow-up one day after a hospital discharge for pneumonia. The nurse did not complete a respiratory assessment.
- In case 56, a patient submitted a sick call with complaints of knee and back pain. The nurse did not assess the patient's back or knee.

Nursing Interventions

Another essential factor for quality nursing care is nursing intervention. SOL nurses intervened timely and appropriately. TTA nurses identified emergencies and intervened immediately. CTC nurses identified changes in patient condition and notified providers as required.

Nursing Documentation

OIG case reviewers often found incomplete documentation in the TTA. During the on-site inspection, case reviewers were informed that the incomplete documentation had already been identified and that staff training was in progress. Please refer to the **Emergency Services** indicator for details.

Correctional treatment center (CTC) nursing staff frequently performed thorough documentation. However, missing documentation was identified in the following three cases:

- In case 3, nurses did not consistently document a patient's intravenous (IV) site and condition and did not consistently document the percentage of meals the patient had eaten.
- In case 58, nurses did not consistently document a patient's Input & Output, and did not consistently document the percentage of meals the patient had eaten.
- In case 61, nurses did not consistently document a patient's IV site and condition.

Nursing Sick Calls

Our case review clinicians reviewed 98 sick call visits. Generally, SOL nurses triaged sick calls appropriately, assessed patients timely, and intervened accordingly. However, there were times the nurses could have

conducted better triage to recognize the urgency of patient complaints and intervene more quickly.

- In cases 10 and 11, a patient with chest pain was not triaged as an emergent sick call patient.
- In case 21, a patient who complained of his “heart not beating as it should” was not assessed the same day, but was evaluated three days later.
- In case 22, a patient complained of vomiting bloodlike mucus and of loss of vision. The patient was seen the following day but should have been evaluated the same day.
- In case 45, a patient submitted a sick call complaining of rectal bleeding and dark stools. The patient was seen the following day but should have been evaluated the same day.

Care Management

Care management involves anticipating patient needs, developing treatment plans, and coordinating care to ensure that services are provided to the patient without interruption or delay. The nurse’s role is to assess, plan, implement, monitor and evaluate patient care. Our case review clinicians examined eight cases involving nurse care management visits and did not identify any deficiencies.²⁹

Wound Care

Wound care performance was mixed. CTC nurses generally provided consistent wound care, accurate documentation, and appropriate interventions. However, in the clinics, wound care delivery was inconsistent and documentation was incomplete. When OIG clinicians reviewed case 20, they identified multiple problems in wound care assessments, documentation, and intervention.

- In case 20, a diabetic patient had a bone infection that required wound care. In their documentation, nurses did not always describe the wound or the care provided.

Emergency Services

SOL nurses responded timely to emergencies and intervened appropriately. OIG clinicians reviewed 42 urgent or emergent events and found 24 deficiencies related to nursing care.³⁰ The deficiencies were minor and related to incomplete documentation and assessments. Similar

29. Nurse care management reviewed cases 9, 10, 17, 19, 22, 23, 25, and 34.

30. Urgent or emergent events occurred in cases 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 19, 20, 22, 23, 24, 25, 26, 27, and 34. Deficiencies occurred in cases 1, 3, 4, 5, 6, 8, 10, 11, 20, 22, 23, 24, 25, 26, and 34.

deficiencies were identified during the Cycle 5 inspection. Please refer to the **Emergency Services** indicator for additional discussion.

Transfers

Although OIG case review clinicians identified nursing deficiencies in the transfer processes, the deficiencies were minor. We reviewed 15 transfers and found 10 deficiencies.³¹

- In cases 3 and 20, nurses did not perform complete initial wound assessments.
- In cases 6 and 8, nurses did not document notification to the provider after evaluations in the off-site emergency room and hospital, respectively.

Please refer to the **Transfers** indicator for details.

Specialized Medical Housing

CTC nurses provided good patient care. Our clinicians reviewed 19 nursing encounters and found nine nursing deficiencies.³² These minor errors were related to documentation. Please refer to the **Specialized Medical Housing** indicator for additional details.

Specialty Services

OIG clinicians reviewed 33 nursing events and found nine nursing deficiencies, of which two were significant.³³ In case 22, there were two occasions in which a nurse did not notify a provider regarding medication recommendations. The remainder of the deficiencies were related to incomplete assessments. The **Specialty Services** indicator provides further information.

Medication Management

SOL performed poorly in medication management. We reviewed 165 medication events in 30 cases.³⁴ Out of the 39 deficiencies identified, 10 were significant.³⁵ Our clinicians identified lapses in medication continuity. Areas of concern include chronic care and hospital returns. Please refer to the **Medication Management** indicator for details.

31. Hospital returns occurred in cases 1, 3, 4, 5, 6, 8, 19, 20, 23, 24, 25, 34, and 61.

32. Nursing care in specialized medical housing occurred in cases 3, 58, 59, and 61. Deficiencies were found in cases 3 and 58.

33. Specialty service nursing events occurred in cases 9, 16, 18, 19, 20, 22, 24, and 28. Deficiencies occurred in cases 18, 20, and 22. Significant deficiencies occurred in case 22.

34. Medication management events occurred in cases 1, 3, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 34, 54, 58, 59, 60, and 61.

35. Significant medication management deficiencies occurred in cases 8, 11, 13, 22, 24, and 28.

Clinician On-Site Inspection

During the on-site inspection, our OIG clinicians attended clinic huddles and interviewed nursing staff. Most required staff attended the huddles and participated in discussions. The clinics did not have any nursing backlog appointments. SOL nurses were knowledgeable about their duties and responsibilities. The medication licensed vocational nurses had a well-organized process for distributing keep-on-person (KOP) medication. We interviewed the chief nurse executive and director of nursing to discuss our case review findings. They acknowledged opportunities for improvement. The supervising registered nurses conduct random monthly audits in each nursing area to identify training issues. Nurse instructors are not only employed to provide required annual training to the nursing staff, but to provide additional training to staff identified by the supervising registered nurses.

Overall, SOL nursing staff expressed job satisfaction, reported a good relationship with custody staff, and described the institution's administration staff as communicative and supportive.

Recommendations

- Nursing leadership should remind nurses to complete assessments and wound care as ordered.
- Nursing leadership should remind nurses to notify providers of specialists' recommendations.

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care from SOL's providers (physicians, physician assistants, and nurse practitioners). Our clinicians assessed providers' ability to properly evaluate, diagnose, and manage their patients. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. The OIG assessed provider care through case review only and performed no compliance testing for this indicator.

Results Overview

SOL providers delivered acceptable care, with fewer deficiencies than in Cycle 5. However, providers continued to show opportunities for improvement in several areas. Providers did not always request appropriate follow-ups and review records carefully. In addition, they did not always document their medical care in the TTA. However, these deficiencies were sporadic. At the on-site inspection, providers reported increased familiarity with the EHRS and improved morale as compared to the prior inspection cycle, despite increased workload and reduced provider availability. Taking all these aspects into consideration, the rating for this indicator was *adequate*.

Case Review Results

OIG clinicians thoroughly reviewed 25 comprehensive cases and found 55 deficiencies in 173 provider encounters. Of those 55 deficiencies, 18 were significant.

Assessment and Decision-Making

SOL providers generally made good assessments and decisions. They addressed patients' complaints, diagnosed correctly, ordered further testing, referred patients for specialty care, and arranged provider follow-ups appropriately. While we found occasional errors, they were not representative of providers' decision-making. OIG clinicians identified room for improvement in several cases.³⁶ Below is a detail from one case:

- In case 15, a provider diagnosed a patient with claudication and ordered Plavix (blood thinner) without diagnostic confirmation. The provider should have ordered ABI (arterial brachial index) before starting the patient on Plavix. Plavix increased the patient's risk of bleeding, particularly because the patient was already taking aspirin.

³⁶ Assessment and decision-making deficiencies occurred in cases 1, 9, 10, 14, 15, 20, 21, 24, and 25.

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
(N/A)

- In case 24, a provider made several errors in assessment and decision-making:
 - The provider prescribed propranolol (a heart medication that slows down the heart rate) to a patient who already had a low heart rate. Further lowering the heart rate reduces blood flow to vital organs of the body.
 - The provider did not reconcile prehospitalization medications for a patient's thyroid and liver problems and the medications were not restarted.
 - The provider did not review a patient's thyroid laboratory test result, and was not aware that the patient was taking thyroid medication. The provider incorrectly documented that the patient was not on thyroid medication and, therefore, made no changes to the medication dosage.

Review of Records

The review of records is a basic and essential component of a provider's evaluation. It is especially important if a patient underwent recent testing, saw a specialist, or returned from a higher level of care. Providers must also review records for unfamiliar patients.

By and large, SOL providers reviewed medical records without any major problems. OIG clinicians identified six deficiencies in five cases involving diabetic care, discharge summaries, laboratory results, and transplant care.³⁷ The following are examples:

- In case 23, a provider did not order general surgery follow-up for a patient with a perforated appendix. Although the patient did not experience complications, the lack of follow-up increased the patient's risk of harm.
- In case 28, a provider was unaware that a patient no longer qualified to be in the kidney transplant program because the patient refused to undergo blood work.

Emergency Care

SOL providers performed well in evaluating patients with urgent or emergent conditions in the TTA. They properly and promptly examined, diagnosed, and triaged these patients. OIG clinicians identified only two deficiencies relating to emergency care.³⁸

37. There were 39 Review deficiencies in cases 18, 20, 23, 24, and 28.

38. Deficiencies were identified in cases 25 and 26.

Please refer to the **Emergency Services** indicator for additional discussion on emergency care.

Chronic Care

In most cases, providers gave good care to patients with chronic medical conditions such as high cholesterol, hypertension, hepatitis C, and asthma. However, there was room for improvement in diabetes care. We found nine deficiencies in four cases.³⁹ Some examples follow:

- In case 15, at two different appointments, a provider noted a patient had uncontrolled diabetes, but did not assess the patient for medication compliance, provide education, and adjust the diabetic medications. Another provider also recognized the patient's poor diabetic control, but ordered a six-month follow-up instead of a shorter interval follow-up. These errors delayed diabetes management.
- In case 20, a provider erroneously noted that a patient was noncompliant with his diabetic medication even though the patient only refused insulin when he had low blood sugars. As a result, the provider did not adjust the patient's insulin to regulate blood sugar levels. This caused the patient to heal slowly after surgical amputations. Later, the provider saw the patient after an emergency room visit and did not take steps to control the patient's diabetes to ensure healing and recovery from infection.

For anticoagulation management, OIG clinicians identified one deficiency in the following case:

- In case 12, the provider completed late reviews of blood tests for a patient who needed close monitoring of coumadin (a blood thinner for reducing the risk of stroke). The provider reviewed a low result 12 days after the result of the blood test was available and delayed ordering a repeat test. Although the repeat test result showed the patient was in the therapeutic range, this delay potentially could have increased the patient's risk of stroke.

Specialty Services

Generally, SOL providers appropriately referred patients for specialty consultations. Providers commonly followed specialists' recommendations. OIG inspectors identified deficiencies in cases 19, 29, and in the following:

- In case 16, a urologist recommended that a patient with invasive prostate cancer undergo a nuclear medicine bone scan with a urology follow-up. The patient's primary care provider (PCP) did not order the bone scan and did not arrange a urology follow-up appointment. This lapse was only resolved when the patient incidentally had chest pain and received a follow-up

39. Deficiencies were identified in cases 15, 16, 20, and 28.

appointment upon returning from the emergency department. At that appointment, the provider finally ordered the bone scan, which was a three-week delay.

Please refer to the **Specialty Services** indicator for additional details regarding provider performance in this area.

Documentation Quality

OIG case reviewers identified deficiencies in SOL providers' documentation in cases 1, 3, 4, 8, 12, 20, and 21. Poor documentation can affect patient care, including emergency care, diagnoses, treatment, and specialty care. The following were examples of poor documentation:

- Providers did not record TTA progress notes in cases 1, 3, 4, and 8.
- In case 12, a patient complained of left shoulder pain. A provider documented the right shoulder examination only, but correctly ordered left shoulder X-rays.

Provider Continuity

During the case review period, one of SOL's providers passed away, two separated from the institution, and three were on vacation. To offset the decreased number of providers, medical leadership shuffled clinic assignments to provide necessary care. Overall, SOL was able to adjust to the loss of providers and maintain continuity. OIG clinicians identified only one deficiency.

Clinician On-Site Inspection

OIG clinicians met with executive leadership and providers and observed provider-patient care processes. The chief medical executive (CME), chief physician and surgeon (CP&S), and providers expressed optimism due to improved intradepartmental collaboration with the new acting CEO and the new acting chief nurse executive. SOL is one of two nonprogramming institutions, and at the time of the inspection, the patient population had increased from 3,500 to 4,600, as reported by the CME.

Per the CME, SOL had 12 providers, including two telemedicine providers and two advanced practitioners. Recently, one provider passed away and two providers separated from the institution. This reduced provider access since March 2019, which led to a backlog of up to 400 patients. At the time of the inspection, two new providers had recently joined and were still in training. SOL still had two vacant positions, and the CME reported that there were no new provider candidates from headquarters for the last two months. To account for reduced provider access, the institution "bundled" appointments, meaning it combined multiple appointment requests into one appointment.

SOL has four yards, A, B, C, and D, which housed level II and III patients with varying medical needs. Certain yards required more medical services while others required fewer. A few months before the on-site inspection, leadership reassigned providers to balance the workload. Some providers expressed disappointment with this change because they had established rapport with their patients and now had to start over. To increase continuity, SOL planned to change the yard-based care teams to the medical record number-based teams at the beginning of 2020 so that a patient's care team would remain the same despite the patient's relocation within SOL.

SOL providers expressed that overall working dynamics have improved since SOL implemented this change. The providers participated in various meetings and were involved in daily huddles. Provider meetings occur on Tuesday mornings. Population management meetings occur once every other week. Provider and nursing staff reported strong interdisciplinary collaboration to improve patient care. Providers reported no difficulties accessing services such as radiology, laboratory, and health information. Likewise, providers reported that they had adjusted to the EHRS.

However, providers voiced concerns about persistent understaffing due to the high provider and nursing turnover rate. This general feeling reflected that of Cycle 5. An additional concern was that headquarters planned on replacing licensed vocational nurses with medical assistants. Providers were concerned that the medical assistants' lower level of training would negatively affect patient care. Providers commented that increased vacancies resulted in increased provider workload and decreased availability of provider appointments.

SOL providers reported that leadership was fair, provided good feedback, and provided routine performance evaluations. The CP&S was always available to help. Some providers were concerned about institutional leadership's strict adherence to InterQual criteria for requests for services. They felt that some patients needed specialty care, but did not get appointments because they did not meet strict criteria. The CME stated that providers have opportunities to discuss these cases at provider meetings and that the provider group decides whether the patient needs specialty care. Leadership and providers felt that telemedicine providers helped with appointment access, but did not deliver the same level of comprehensive care as on-site providers.

Recommendations

- Medical leadership should remind providers to document physician-on-call and TTA encounters.
- Institutional leadership should review and delineate providers' responsibilities for reconciling medications and orders upon a patient's arrival or return to the institution.
- Institutional leadership should continue to support collaboration between providers, nurses, custody staff, and ancillary staff.

Overall
Rating
Proficient

Case Review
Rating
Proficient

Compliance
Score
Adequate
(82%)

Specialized Medical Housing

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. SOL's only specialized medical housing unit is a correctional treatment center (CTC). Our clinicians focused on medical staff's ability to assess, monitor, and perform interventions for medically complex patients who require close medical supervision. We evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We also assessed staff's ability to respond promptly when patients' conditions deteriorated. Our clinicians looked for good communication when staff consulted one another to provide continuity of care. Our clinicians interpreted relevant compliance results and incorporated them into this indicator. When rating this indicator, the OIG strongly considered the case review test results, which reflected the quality of care to a greater degree than compliance testing.

Results Overview

SOL providers and nurses delivered excellent care in the CTC. Compared to Cycle 5, SOL had slightly more deficiencies, but none were significant. Providers completed timely history and physicals with routine interval evaluations. Nurses provided good care with minor documentation deficiencies. SOL achieved a *proficient* rating for this indicator.

Case Review Results

OIG clinicians reviewed six CTC cases, which included 26 provider events and 19 nursing events. Each provider and nursing event can represent up to one month of provider care and one week of nursing care, respectively. OIG clinicians identified 12 deficiencies, none of which were significant.

Provider Performance

Providers delivered quality care in the CTC. In compliance sampling, every new patient admitted to the CTC received a written history and physical examination within the required time frames (MIT 13.002, 100%), but did not complete provider rounding as required (MIT 13.003, 50%). Notably the low score is attributed to two progress notes, each of which were delayed by one day. The other 24 rounding progress notes in two compliance samples were timely.

In case review testing, SOL providers performed well in CTC patient care. They made sound assessments and appropriate decisions. Our clinicians identified only two minor deficiencies in one case.

- In case 23, a provider admitting a patient to the CTC did not order an outpatient surgery follow-up, which was necessary because the patient had been discharged from the outside hospital after having a ruptured appendix and abscess. Although

this patient recovered without the follow-up, improper review and failure to follow hospital discharge recommendations falls short of community standards. Also, in this case, the assessment and plan sections of the provider's progress notes contained language that was identical to what appeared in another provider's notes.

Nursing Performance

CTC nurses provided very good patient care. They completed assessments and intervened timely. Admission assessments were completed upon a patient's arrival in the CTC (MIT 13.001, 100%). The nurses ensured that, upon admission, patients were educated on the use of the patient call system (MIT 13.101, 100%). In the cases reviewed, OIG clinicians identified minor documentation issues. The nurses were not always consistent in recording the percentage of meals patients ate and the effectiveness of as-needed medications.

Although OIG case reviewers did not find medication issues for patients admitted to the CTC, compliance findings showed otherwise. Upon admission to the CTC, patients received their medications within the required time frame in 60 percent of the samples tested (MIT 13.004). When the OIG clinicians analyzed this low compliance score, they determined that the medication delays were not clinically significant.

Clinician On-Site Inspection

The CTC had six beds for medical patients and one negative pressure room. Staffing for each shift had three registered nurses. Second watch registered nurses perform wound care. Patient discharges occur on second watch and patient admissions occur on third watch. Due to provider shortage, there is no dedicated CTC provider; the providers care for their patients in their primary clinic and follow them into the CTC. The second watch nurses perform a huddle and notify the provider of any status changes. Providers rounded on their patients in the CTC every three days. CTC nursing staff reported they have a good rapport with custody staff.

Recommendations

- Institutional leadership should ensure that newly admitted CTC patients receive their medications timely to maintain medication continuity.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	10	0	0	100%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	2	2	6	50%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	6	4	0	60%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	100%
Overall percentage (MIT 13): 82%				

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

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

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

Specialty Services

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

Results Overview

SOL provided appropriate specialty services. As compared to Cycle 5, the OIG inspectors noted a reduction in deficiencies. The institution generally provided acceptable specialty access for patients, but did not always reconcile previously approved orders when patients transferred into the institution or returned from the hospital. Providers usually referred their patients to specialists accordingly and followed specialists' recommendations. Nurses assessed and intervened appropriately when patients returned from specialty appointments and requested follow-up appointments with their providers. However, nurses did not relay all specialty recommendations to the providers. Specialty reports were generally scanned promptly, but provider endorsement could have been more timely. Considering all factors, the rating for this indicator was *adequate*.

Case Review Results

OIG clinicians reviewed 148 events related to this indicator, which included 115 specialty consultations and procedures. They found 40 deficiencies, six of which were significant. While the percentage of total specialty deficiencies was comparable to Cycle 5, the proportion of significant deficiencies was much smaller.

Access to Specialty Services

SOL had a mixed performance with access to specialty services. In compliance testing, SOL performed well in providing access to specialty services for patients at the institution, and scored notably in meeting policy-required time frames for routine-priority (MIT 14.007, 100%), medium-priority (MIT 14.004, 87%), and high-priority (MIT 14.001, 100%) appointments. However, SOL did not perform well with access to preapproved specialty services when patients transferred into the institution (MIT 14.010, 40%). Case review clinicians found that staff were not clear on their responsibilities for ordering preapproved specialty services for newly arrived patients. However, within EHR workflows, only nurses can enter referral-to orders and only providers can enter specialty follow-up orders.⁴⁰

Overall
Rating
Adequate

Case Review
Rating
Adequate

Compliance
Score
**Adequate
(84%)**

40. The referral-to orders are preapproved specialty orders.

Case review clinicians found 10 deficiencies, three of which were significant.⁴¹ We identified two specific patterns that contributed to these deficiencies. First, providers requested testing dates in the comments section of the EHRS order that did not match the standard order time frame in the EHRS. Secondly, SOL did not always reconcile specialty appointments after a patient returned from a hospital stay. The latter pattern was also present in Cycle 5. Please refer to the **Access to Care** indicator for more details.

Provider Performance

SOL providers performed well with specialty care and referred patients appropriately to the correct specialists. We found three instances in which providers entered a compliance date in the comment section of the request for service that differed from the priority classification compliance dates.⁴² The institution scheduled the appointment by the priority classification compliance date instead. This was also discussed in the **Access to Care** indicator.

- In case 20, a provider requested an urgent magnetic resonance imaging scan (MRI) to assess for a bone infection. The provider ordered the MRI as a high-priority service and wrote in the comment section of the order that the MRI be scheduled for the next day. Because the provider requested a high-priority service (one that must be performed within 14 days) instead of entering a request for service for an urgent or emergent appointment, the MRI was scheduled nine days later. The provider's specific direction on scheduling was not followed.

Generally, SOL providers arranged appropriate follow-up care after specialty consultations. Compliance testing showed similar results with providers seeing their patients promptly following a specialty appointment (MIT 1.008, 81%).

Nursing Performance

SOL TTA nurses usually assessed patients thoroughly and documented their care accurately after off-site specialty appointments. OIG case reviewers identified one case in which this did not occur.

- In case 22, a patient who had previously undergone a corneal transplant and retinal detachment repair, returned from an ophthalmology appointment. However, upon return from the off-site appointment, the out-to-medical nurse did not completely assess the patient's eyes.

Out-to-medical nurses usually relayed off-site recommendations to the providers; however, we identified lapses in communication between

41. Specialty access deficiencies were identified in cases 16, 20, 22, 23, 26, 27, 28, 29, and 30. Significant deficiencies were found in cases 16, 20, and 27.

42. This type of deficiency was found in cases 20, 22, and 23.

nurses and providers on three separate occasions for the same case discussed above—case 22. All three lapses involved medication orders.

SOL nursing leadership acknowledged these deficiencies at the on-site inspection. Leadership reported that retraining of the out-to-medical registered nurses had already been initiated to correct this lapse.

Health Information Management

SOL mostly scanned time-specified priority notes promptly (MIT 4.002, 87%) in compliance testing. OIG case review testing found late specialty report retrieval and scanning in three cases: 15, 20, and the following:

- In case 29, a patient saw an endocrine specialist. The dictated notes following the appointment were not scanned into the EHRS until 14 days after the appointment.

SOL retrieved and had providers review routine-priority reports (MIT 14.008, 73%), medium priority reports (MIT 14.005, 60%), and high-priority specialty reports (MIT 14.002, 87%) within the specified time frames.

Similarly, OIG clinicians found that providers did not review specialty reports timely in cases 15, 20, 22, 27, 29, and 30.

- In case 30, a patient saw a telemedicine gastrointestinal medicine specialist for a follow-up for ulcerative colitis. The provider reviewed and signed the specialty report six days late.

Please refer to the **Health Information Management** indicator for additional details.

Clinician On-Site Inspection

SOL staff reported that on-site specialty services included ophthalmology, optometry, podiatry, orthotics and audiology. The CP&S managed the procedure clinic and the nurses handled the clinics for nail trimming and removal, including the clinics in which patients may check out tools to trim their own nails. SOL had only one backlog for specialty appointments, which was directly related to the patient's condition.

Staff voiced concern about having limited access to ophthalmology and oncology vendors, which are shared with other institutions. Providers expressed reservations about the request for services process. They felt leadership was too strict in adhering to InterQual criteria thus limiting specialty access for patients who need specialty care but do not meet the specific criteria. Medical leadership responded that if a request for service is not approved, providers can bring the case to a providers' meeting for peer review.

We had a discussion with the medical leadership about a nuclear medicine stress test that was incorrectly ordered. The nuclear medicine stress test request for services was submitted as a radiology diagnostic

order rather than a cardiac nuclear medicine order. Medical leadership stated that providers can order the stress test either through a radiology order or through utilization management. Both radiology and utilization management staff explained that a cardiac nuclear medicine stress test must be ordered as a cardiac nuclear medicine order and evaluated through utilization management.

Providers told us they sign specialty reports timely, but because they are short on providers, they try to arrange proxy coverage. Health information management supervisors occasionally run audit reports on providers' signature compliance on specialty reports; however, the reports are neither routine nor automatic, and the health information management department has been short-staffed as well.

By speaking with nursing staff, our clinicians confirmed that the reconciliation of specialty orders for newly arrived patients did not always occur. Nurses stated that while providers were responsible for completing the reconciliation, the providers believed that nursing staff were responsible for it. Lack of reconciliation led to specialty orders being canceled and, ultimately, to patients not being seen appropriately.

Recommendations

- Executive leadership should review and define staff responsibilities of ordering preapproved specialty services for patients newly arriving to the institution.
- Executive leadership should review and define staff responsibilities for reconciling all orders upon a patient's return from the hospital.
- Medical records staff should perform routine scheduled reviews to ensure the review and endorsement of specialty reports.
- Medical leadership should remind providers about their specialty ordering process.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	15	0	0	100%
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) *	13	2	0	87%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	10	1	4	91%
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) *	13	2	0	87%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	9	6	0	60%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	4	0	11	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	15	0	0	100%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	11	4	0	73%
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	0	9	100%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	8	12	0	40%
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)	15	5	0	75%
Overall percentage (MIT 14): 84%				

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

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

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) ^{*,†}	35	8	2	81%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	87%

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

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

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

Administrative Operations

In this indicator, OIG compliance inspectors examined administrative health care 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 if the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee met regularly and addressed program performance adequately. Also, the inspectors examined if the institution provided training and job performance reviews for its employees. They checked whether staff possessed current and 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 affected clinical patient care directly (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Compliance Testing Results

Nonscored Results

We obtained California Correctional Health Care Services' (CCHCS) Death Review Committee (DRC) reporting data and found that three unexpected (Level 1) deaths occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of a death. The DRC must submit the death review summary report to the institution's CEO within seven calendar days of completing it. In our inspection, we found the DRC completed one death review report promptly and finished two other reports 120 and 199 days late, respectively. Upon completion of the reports, the DRC submitted them to the institution's CEO nine to 41 days later (MIT 15.998).

Recommendations

- The EMRRC should review emergency medical response incidents timely at the regular monthly meeting following the date of the incidents.
- Nursing leadership should ensure that annual clinical competency testing for nursing staff is conducted timely.

Overall
Rating
Inadequate

Case Review
Rating
(N/A)

Compliance
Score
Inadequate
(71%)

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	0	3	0	0
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)	0	12	0	0
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent, meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	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 inmates' grieved issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	2	0	1	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	8	0	0	100%
Did the providers maintain valid state medical licenses? (15.106)	10	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? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
Overall percentage (MIT 15): 71%				

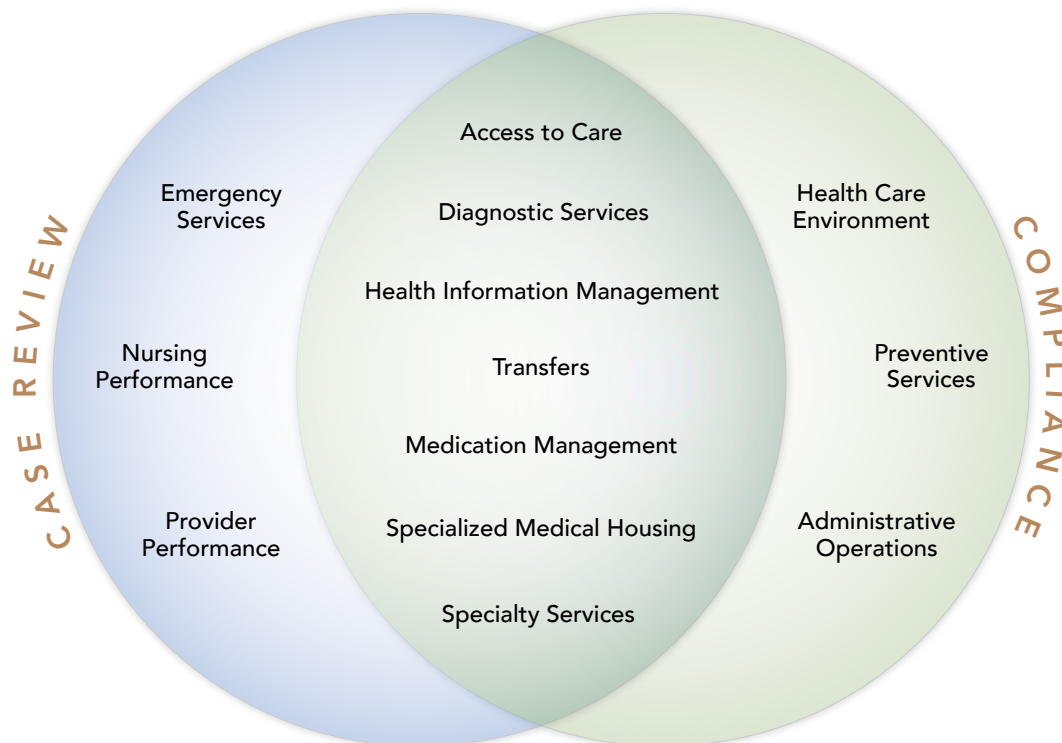
Source: The Office of the Inspector General medical inspection results.

Appendix A: Methodology

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

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

Figure A-1. Inspection Indicator Review Distribution for SOL



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

Case Reviews

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

Table A-1. Case Review Definitions

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

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

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

Case Review Sampling Methodology

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

After applying filters, analysts follow a standardized protocol and select samples for clinicians to review. Samples are obtained per the case review methodology shared with stakeholders in prior cycles. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

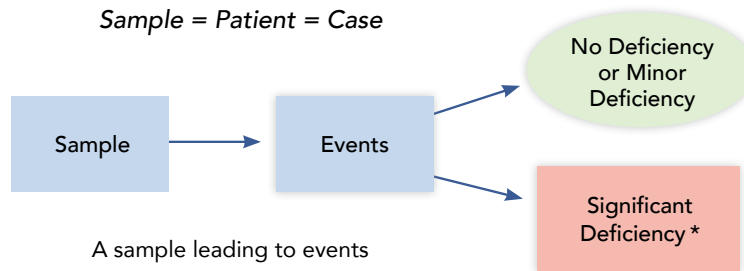
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review *events*. Our clinicians also record medical errors, which we refer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

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

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

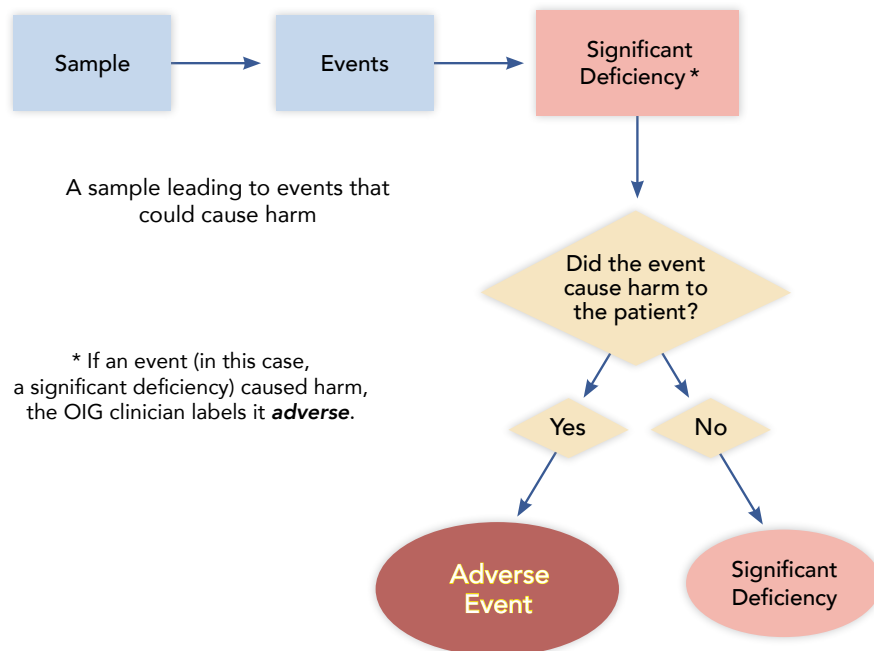
Figure A-2. Case Review Testing

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



Deficiencies

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



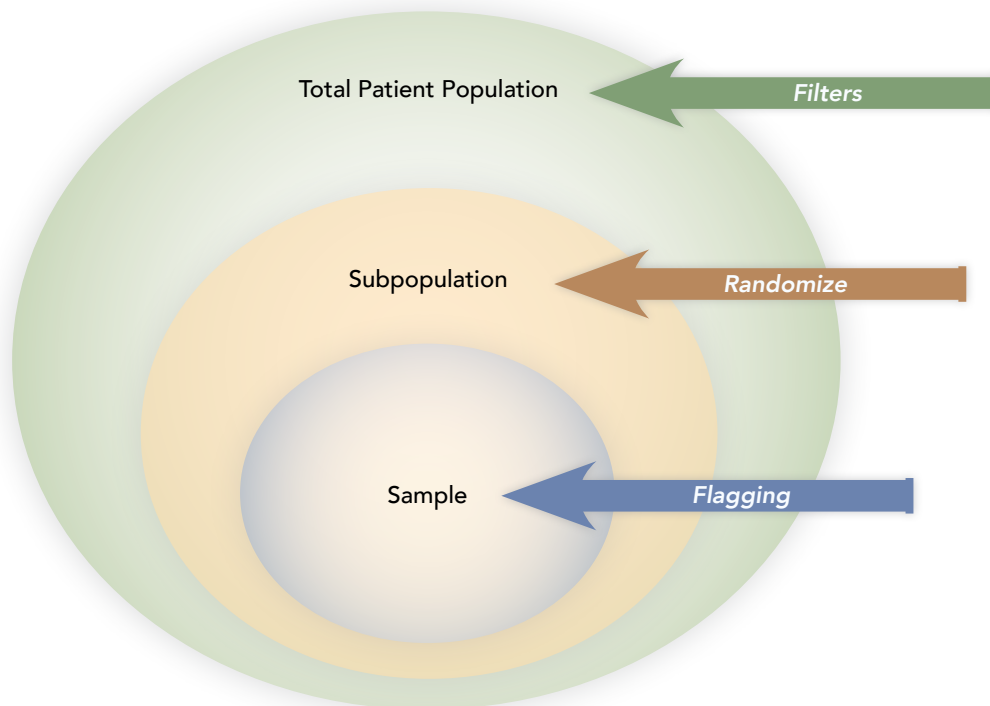
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A-3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

Our compliance team calculates the percentage of all *Yes* answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

Indicator Ratings and the Overall Medical Quality Rating

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

Appendix B: Case Review Data

Table B–1. Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	20
Specialty Services	4
	60

Table B–2. Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	10
Anticoagulation	3
Arthritis/Degenerative Joint Disease	4
Asthma	7
COPD	8
Cancer	6
Cardiovascular Disease	7
Chronic Kidney Disease	9
Chronic Pain	18
Cirrhosis/End-Stage Liver Disease	9
Coccidioidomycosis	3
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	18
Gastroesophageal Reflux Disease	13
Gastrointestinal bleed	2
HIV	1
Hepatitis C	20
Hyperlipidemia	24
Hypertension	37
Mental Health	18
Seizure Disorder	2
Sleep Apnea	3
Thyroid Disease	1
	225

Table B–3. Case Review Events by Program

Diagnosis	Total
Diagnostic Services	182
Emergency Care	64
Hospitalization	32
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
Not Specified	5
Outpatient Care	494
Specialized Medical Housing	74
Specialty Services	161
	1,018

Table B–4. Case Review Sample Summary

MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	16
RN Reviews Focused	34
Total Reviews	75
Total Unique Cases	60
Overlapping Reviews (MD & RN)	15

Appendix C: Compliance Sampling Methodology

California State Prison, Solano

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Access to Care</i>				
MIT 1.001	Chronic Care Patients	25	Master Registry	<ul style="list-style-type: none"> Chronic care conditions (at least one condition per patient—any risk level) Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	<ul style="list-style-type: none"> See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	MedSATS	<ul style="list-style-type: none"> Clinic (each clinic tested) Appointment date (2–9 months) Randomize
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	<ul style="list-style-type: none"> Randomly select one housing unit from each yard
<i>Diagnostic Services</i>				
MITs 2.001–003	Radiology	10	Radiology Logs	<ul style="list-style-type: none"> Appointment date (90 days–9 months) Randomize Abnormal
MITs 2.004–006	Laboratory	10	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
MITs 2.010–012	Pathology	10	InterQual	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Service (pathology related) Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Health Information Management (Medical Records)</i>				
MIT 4.001	Health Care Services Request Forms	20	OIG Qs: 1.004	<ul style="list-style-type: none"> • Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	30	OIG Qs: 14.002, 14.005 & 14.008	<ul style="list-style-type: none"> • Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	20	OIG Q: 4.005	<ul style="list-style-type: none"> • Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
<i>Health Care Environment</i>				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	9	OIG inspector on-site review	<ul style="list-style-type: none"> • Identify and inspect all on-site clinical areas.
<i>Transfers</i>				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	<ul style="list-style-type: none"> • Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	5	OIG inspector on-site review	<ul style="list-style-type: none"> • R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Pharmacy and Medication Management</i>				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See Access to Care <ul style="list-style-type: none"> At least one condition per patient—any risk level Randomize
MIT 7.002	New Medication Orders	21	Master Registry	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	<ul style="list-style-type: none"> Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	25	Medication error reports	<ul style="list-style-type: none"> All medication error reports with Level 4 or higher Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Isolation Unit KOP Medications	10	On-site active medication listing	<ul style="list-style-type: none"> KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Prenatal and Postpartum Care</i>				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	<ul style="list-style-type: none"> • Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	<ul style="list-style-type: none"> • Arrival date (2–12 months) • Earliest arrivals (within date range)
<i>Preventive Services</i>				
MITs 9.001–002	TB Medications	18	Maxor	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary)	N/A at this institution	Cocci transfer status report	<ul style="list-style-type: none"> • 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
<i>Reception Center</i>				
MITs 12.001–008	RC	N/A at this institution	SOMS	<ul style="list-style-type: none"> • Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
<i>Specialized Medical Housing</i>				
MITs 13.001–004	Specialized Health Care Housing Unit	10	CADDIS	<ul style="list-style-type: none"> • Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MIT 13.101	Call Buttons	All	OIG inspector on-site review	<ul style="list-style-type: none"> • Specialized Health Care Housing • Review by location
<i>Specialty Services</i>				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MIT 14.010	Specialty Services Arrivals	20	MedSATS	<ul style="list-style-type: none"> • Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	<ul style="list-style-type: none"> • Review date (3–9 months) • Randomize
		0	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> • Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Administrative Operations</i>				
MIT 15.001	Adverse/sentinel events	3	Adverse/sentinel events (ASE) report	<ul style="list-style-type: none"> Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	<ul style="list-style-type: none"> Monthly meeting minutes (6 months)
MIT 15.004	LGB	N/A	LGB meeting minutes	<ul style="list-style-type: none"> Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	<ul style="list-style-type: none"> Most recent full quarter Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	<ul style="list-style-type: none"> Medical grievances closed (6 months)
MIT 15.103	Death Reports	3	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> Most recent 10 deaths Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	<ul style="list-style-type: none"> On duty one or more years Nurse administers medications Randomize
MIT 15.105	Provider Annual Evaluation Packets	8	On-site provider evaluation files	<ul style="list-style-type: none"> All required performance evaluation documents
MIT 15.106	Provider Licenses	10	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	<ul style="list-style-type: none"> All staff <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> All required licenses and certifications

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Administrative Operations</i>				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	<ul style="list-style-type: none"> New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	3	OIG summary log: deaths	<ul style="list-style-type: none"> Between 35 business days & 12 months prior Health Care Services death reviews

California Correctional Health Care Services' Response

June 19, 2020

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

Dear Mr. Wesley:

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

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

Sincerely,



DeAnna M. Gouldy

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

cc: Clark Kelso, Receiver

Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Katherine Tebrock, Chief Assistant Inspector General, OIG
Doreen Pagan, R.N., Nurse Consultant Program Review, OIG
Jennifer Barretto, Director, Health Care Policy and Administration, CCHCS
R. Steven Tharratt, M.D., M.P.V.M., FACP, Director, Health Care Operations, CCHCS
Joseph Bick, M.D., Director (A), Division of Correctional Health Care Services, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Lara Saich, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbra Barney-Knox, R.N., Deputy Director (A), Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Rainbow Brockenborough, Regional Health Care Executive (A), Region I, CCHCS
Jasdeep Bal, M.D., Regional Deputy Medical Executive, Region I, CCHCS
Deborah Bradford, R.N., Regional Nursing Executive, Region I, CCHCS
Lisa McGhee, Chief Executive Officer (A), SOL
Amanda Oltean, Staff Services Manager II, Program Compliance Section, CCHCS
Kristine Lopez, Staff Services Manager I, Program Compliance Section, CCHCS
Misty Polasik, Staff Services Manager I, OIG



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

(This page left blank for reproduction purposes.)

Cycle 6
Medical Inspection Report

for

California State Prison
Solano

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
September 2020

OIG