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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

September 2021

Cycle 6
Medical Inspection Report

Substance Abuse Treatment Facility and State Prison at Corcoran

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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[1] in the California Department of Corrections and Rehabilitation (the department).[2]

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.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in response to compliance- and performance-related questions as established in the medical inspection tool (MIT).[4] 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.[5] 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. In this report, we use the terms *patient* and *patients* to refer to *incarcerated persons*.

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

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

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

5. 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 Substance Abuse Treatment Facility and State Prison at Corcoran (SATF), the receiver had not delegated this institution back to the department.

We completed our sixth inspection of SATF and herein present our assessment of the health care provided at SATF during the inspection period between January 2020 and June 2020.[6] Our case reviews encompassed patients during the COVID-19 pandemic. The inspection was otherwise completed with no further adjustments.

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

6. Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between July 2019 and June 2020, emergency non-CPR reviews that occurred between January 2020 and July 2020, hospitalization reviews that occurred between January 2020 and July 2020, transfer-in reviews between October 2019 and April 2020, RN sick-call reviews between January 2020 and August 2020, and correctional treatment center (CTC) reviews between October 2019 and March 2020.

Summary

We completed the Cycle 6 inspection of Substance Abuse Treatment Facility (SATF) in December 2020. OIG inspectors monitored the institution's delivery of medical care that occurred between January 2020 and June 2020.

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

Table 1. SATF Summary Table

Ratings

Proficient *Adequate* *Inadequate*

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

* 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 440 patient records and 1,183 data points and used the data to answer 93 policy questions. In addition, we observed SATF's processes during an on-site inspection in November 2020. Table 2 below lists SATF's average scores from Cycles 4, 5, and 6.

The OIG clinicians reviewed 58 cases, which contained 813 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in December 2020 to verify their initial findings. The OIG physicians rated the quality of care for 23 comprehensive case reviews. Of these 23 cases, our physicians rated

Table 2. SATF Policy Compliance Scores

Scoring Ranges

100%–85.0%	84.9%–75.0%	74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	80.3%	71.7%	45.9%
2	Diagnostic Services	76.7%	54.9%	44.7%
4	Health Information Management	68.9%	60.7%	83.0%
5	Health Care Environment	80.4%	69.4%	57.1%
6	Transfers	80.3%	80.7%	51.1%
7	Medication Management	73.3%	72.7%	67.7%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	64.7%	77.9%	60.4%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	84.0%	85.0%	81.6%
14	Specialty Services	71.2%	72.3%	56.2%
15	Administrative Operations	73.4%*	78.4%	66.5%

* 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.

15 adequate and eight inadequate. Our physicians did not find any adverse deficiencies during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions from them, which we report in the 13 health care indicators.[7] Quality control reviews by multiple OIG clinicians and collective deliberations ensured consistency, accuracy, and thoroughness. The OIG clinicians acknowledged mitigating factors (i.e., the institution's systemic checks and balances). As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the SATF Summary Table.

In July 2020, the Health Care Services Master Registry showed that SATF had a total population of 4,706. A breakdown of the medical risk level of the SATF population as determined by the department is set forth in Table 3 below.[8]

Table 3. SATF Master Registry Data as of July 2020

Medical Risk Level	Number of Patients	Percentage
High 1	233	5.0%
High 2	391	8.3%
Medium	2,532	53.8%
Low	1,550	32.9%
Total	**4,706**	**100%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 07-31-20.

7. The indicators for **Reception Center** and **Prenatal Care** do not apply to SATF.
8. For a definition of medical risk, see CCHCS HCDOM 1.2.14, Appendix 1.9.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, SATF had zero executive leadership vacancies, 2.5 vacant primary care provider positions, zero vacant nursing supervisor positions, and 3.8 vacant nursing staff positions.

Table 4. SATF Health Care Staffing Resources as of July 2020

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5	13.5	18.2	136	172.7
Filled by Civil Service	6	11	18	132.2	167.2
Vacant	0	2.5	0	3.8	6.3
Percentage Filled by Civil Service	120.0%	81.5%	99.0%	97.2%	96.8%
Filled by Telemedicine	0	3	0	0	3
Percentage Filled by Telemedicine	0	22.2%	0	0	1.7%
Filled by Registry	0	0.4	0	15	19.4
Percentage Filled by Registry	0	3.0%	0	11.0%	8.7%
Total Filled Positions	6	14.4	18	147.2	185.6
Total Percentage Filled	120.0%	106.7%	99.0%	108.2%	107.5%
Appointments in Last 12 Months	2	0	2	26	30
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	1	4	5
Adjusted Total: Filled Positions	**6**	**14.4**	**17**	**143.2**	**180.6**
Adjusted Total: Percentage Filled	**120.0%**	**106.7%**	**93.4%**	**105.3%**	**104.6%**

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 6 medical inspection preinspection questionnaire received July 2020, from California Correctional Health Care Services.

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.[9]

The OIG did not find any adverse events at SATF during the Cycle 6 inspection.

Case Review Results

OIG case reviewers assessed 10 of the 13 indicators applicable to SATF. Of these 10 indicators, OIG clinicians rated three ***adequate*** and seven ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 23 detailed case reviews they conducted. Of these 23 cases, 15 were ***adequate***, and eight were ***inadequate***. In the 813 events reviewed, there were 352 deficiencies, 104 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 SATF:

- Medical providers felt supported and had trust in their medical leadership.
- The triage and treatment area (TTA) staff provided good care by appropriately triaging and transferring patients out to the hospital when they needed a higher level of care.
- TTA nurses assessed patients who returned from the hospital and specialists appropriately reviewed recommendations and provided proper handoff communications to care teams.

Our clinicians found the following weaknesses at SATF:

- Urine culture results were not available in the EHRS. This prevented providers from determining the proper antibiotic for the patients' infections.
- Providers sometimes inappropriately rescheduled patients whose conditions required prompt medical attention.

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

- SATF did not always retrieve specialty reports and have providers endorse them in a timely manner.
- The medication administration record did not always reflect chronic care medication continuity.
- Case review clinicians observed nurses documenting treatment plans before evaluating patients for their sick call complaints.
- Nurses did not always perform complete assessments and timely notify providers when patients had urgent symptoms.

Compliance Testing Results

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

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

- The institution's medical staff timely scanned requests for health care services and community hospital discharge reports into patients' electronic medical records.
- Providers and nursing staff performed well in completing initial assessments and evaluating patients admitted to specialized medical housing.

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

- The institution did not consistently provide radiology, routine laboratory, and stat (immediate) laboratory services within specified time frames.
- Providers did not often communicate the results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic results, and whether the results were within normal limits.
- The institution failed to provide chronic care, specialty services, and hospital discharge follow-up appointments within the required time frames. Furthermore, patients were not referred to their providers within the required time frames upon their arrival at the institution.
- SATF staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to a specialized medical housing unit. In addition, there was poor medication continuity for patients who transferred into the institution.

Population-Based Metrics

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

HEDIS Results

We considered SATF's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. SATF's results were mixed compared with those found in state health plans for diabetic care measures. We list the nine 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), SATF performed better in two of the three diabetic measures. SATF scored lower than Kaiser Southern California with regard to blood pressure control and eye examinations.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. SATF had a 63 percent influenza immunization rate for adults 18 to 64 years old and a 78 percent influenza immunization rate for adults 65 years of age and older. The pneumococcal vaccination rate was 94 percent.[10]

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

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include this data for informational purposes. SATF had a colorectal cancer screening rate of 67 percent.

Table 5. SATF Results Compared With State HEDIS Scores

HEDIS Measure	SATF Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**100%**	88%	94%	95%
Poor HbA1c Control (>9.0%)‡,§	**11%**	34%	24%	20%
HbA1c Control (<8.0%)‡	**76%**	–	–	–
Blood Pressure Control (<140/90)‡	80%	–	75%	**85%**
Eye Examinations	36%	–	–	–
Influenza–Adults (18–64)	63%	–	–	–
Influenza–Adults (65+)	78%	–	–	–
Pneumococcal–Adults (65+)	94%	–	–	–
Colorectal Cancer Screening	67%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in November 2020 by reviewing medical records from a sample of SATF's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled, *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2018–June 30, 2019 (published June 2020).

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

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

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

Recommendations

As a result of our assessment of SATF's performance, we offer the following recommendations to the department. Where we recommend an internal review of the root causes of identified problems, we further recommend that the institution consider all remedial measures to address challenges, including both systemic adjustments and individual accountability.

Access to Care

- Medical leadership should remind providers to complete a thorough and complete review of patients' medical records before deferring appointments, and to only defer those that do not pose an increased medical risk.
- Medical leadership should determine the cause of challenges in the timely provision of chronic care follow-up appointments with providers, nurse-to-provider referrals, specialty appointments, and follow-up specialty appointments and implement remedial measures as appropriate.
- Medical leadership should ensure sufficient patient health care service request forms are available.
- Nursing leadership should review the pattern of populating treatment plans before seeing patients and implement remedial measures as appropriate.

Diagnostic Services

- Laboratory supervisors should review the process of obtaining urine culture results and ensure the results are in the EHRS.
- Medical leadership should determine the cause of untimely radiology, laboratory, and pathology services and implement remedial measures as appropriate.
- Medical leadership should determine the cause of challenges in the endorsement of laboratory results and implement remedial measures as appropriate to ensure the results are endorsed within required time frames.
- Medical leadership should determine the cause of the untimely receipt of pathology reports and implement remedial measures as appropriate.
- Nursing leadership should determine the cause of the untimely notification of stat laboratory results to providers and implement remedial measures as appropriate.
- The department should consider developing and implementing a patient results letter template for laboratory, radiology, and

pathology results that autopopulates with all elements required per CCHCS policy.

Health Information Management

- The department should review how the laboratory's results auto populate into the EHRS to ensure timely and accurate availability of laboratory urine culture results.
- Medical leadership should consider requesting provider access and training providers to review the laboratory's web reporting portal. In addition, leadership should consider assigning staff to track all laboratory test results to ensure the results are reported in the EHRS.
- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required by CCHCS policy.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should have each clinic nurse supervisor review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed. In addition, nursing leadership should implement random monthly inventory spot checks to ensure EMRBs contain all medical supplies identified in the logs.
- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.

Transfers

- Nursing leadership should ensure receiving and release (R&R) nurses complete a patient face-to-face visit 24 hours before a patient is transferred out of the institution.
- The department should consider developing and implementing an electronic alert to ensure R&R nurses properly complete initial screening questions and follow up as needed, that providers see patients in the time frame required based on the patient's clinical risk level, and that specialty appointments are scheduled within the required time frame.
- Nursing leadership should determine the cause of challenges in the provision of medications to newly arriving patients without interruption and implement remedial measures as appropriate.

Medication Management

- Medical leadership should determine the cause of challenges related to chronic care medication continuity and implement remedial measures as appropriate.
- CCHCS should consider developing an EHRS notification to the patient care team if keep-on-person (KOP) medications are not picked up by the patient before the medications are disposed of.

Preventive Services

- Medical leadership should determine the cause of challenges related to screening patients annually for tuberculosis (TB) and implement remedial measures as appropriate.
- Medical leadership should remind nursing staff to perform weekly monitoring and address the symptoms of patients taking TB medications.[11]

Nursing Performance

- Nursing leadership should ensure nurses perform more detailed assessments and interventions at each high-risk chronic care patient visit.
- Nursing leadership should remind nurses to assess patients for sick call requests prior to writing an intervention plan on the sick call slip.
- Nursing leadership should remind nurses to triage urgent symptomatic sick call requests timely.

Provider Performance

- Medical leadership should ensure every provider has access to the web laboratory portal (Care 360) to review culture results or pathology results, as those results do not populate into the EHRS.
- Medical leadership should remind providers to fully document their co-consults with nurses in the EHRS.

Specialized Medical Housing

- Nursing leadership should determine the root cause of challenges in patients receiving all ordered medications within the required time frame and implement remedial measures as appropriate.

11. In April 2020, CCHCS reported adding the symptom of *fatigue* into the EHRS powerform for tuberculosis (TB)-symptom monitoring.

- Nursing leadership should consider ways of improving patient handoff between the CTC and the telemedicine nurse after wound care specialty consults.

Specialty Services

- Institutional leadership should remind both providers and nurses to review specialty reports within the required time frames and implement remedial measures as appropriate.
- Medical leadership should identify the cause of the lack of the timely specialty appointments and subsequent follow-up visits and implement remedial measures as appropriate.
- Medical leadership should determine the cause of challenges in notifying patients of specialty denials within the required time frame and implement remedial measures as appropriate.
- Medical leadership should determine the cause of the untimely provision of ordered specialty services and subsequent follow-up visits and implement remedial measures as appropriate.

Access to Care

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(45.9%)

Results Overview

SATF provided poor access to care. Compliance testing showed poor provider access, specialty access, and provider access after hospitalization and specialty visits; however, compliance testing showed good access to nurses and providers in specialized medical housing and in the triage and treatment area. Case reviewers also found issues with provider access, specialty access, and access to providers after hospitalizations. On-site, we observed nurses completing plan of care clinical forms before assessing patients. This will be discussed in the **Nursing Performance** indicator. After reviewing all aspects of this indicator, including those pertaining to the COVID-19 pandemic, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 274 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified 26 deficiencies relating to access to care, 14 of which were significant.[12]

Access to Clinic Providers

SATF performed poorly with access to clinic providers. Failure to ensure provider appointment availability can cause lapses in care. Compliance testing scores pertaining to the timeliness of chronic care appointment follow-up (MIT 1.001, 32.0%), RN-to-provider referrals (MIT 1.005, 10.0%), and provider follow-up appointments (MIT 1.006, zero) were very low. Case reviewers examined 274 outpatient provider encounters in 24 cases and identified five deficiencies in case 23 and in the following:

- In case 18, a chronic care appointment occurred 17 days later than requested.
- In case 25, a chronic care appointment was scheduled but did not occur. By the end of the review period, the patient did not have a chronic care appointment for over two years.

12. Deficiencies were found in cases 3, 10, 14, 16, 18, 20, 21, 22, 23, 25, 32, 35, 36, and 56. Significant deficiencies were found in 16, 20, 21, 22, 23, 25, and 56.

Access to Specialized Medical Housing Providers

SATF ensured access to specialized medical housing providers. The compliance testing score for appropriate history and physical admissions in specialized medical housing was good (MIT 13.002, 88.9%). Case reviewers did not identify any deficiencies related to access to specialized medical housing providers.

Access to Clinic Nurses

SATF provided excellent access to nurses via registered nurse (RN) sick calls. Compliance testing scores demonstrated both very good access with same-day triage (MIT 1.003, 97.5%) and one-day face-to-face sick call (MIT 1.004, 94.9%). OIG clinicians did not find any deficiencies with access to clinic nurses. This will be discussed further in the **Nursing Performance** indicator.

Access to Specialty Services

SATF performed poorly in providing access to specialty services. Compliance testing showed respectable scores for high-priority specialty access (MIT 14.001, 86.7%), but poor scores for medium-priority (MIT 14.004, 60.0%) and routine-priority (MIT 14.007, 66.7%) specialty access. Staff had mixed performance in providing patients with access to high-priority, medium-priority, and low-priority specialist follow-up appointments (MIT 14.003, 58.3%, MIT 14.006, 83.3%, and MIT 14.009, 42.9%). Case reviewers found nine deficiencies in six out of 20 applicable cases.[13]

- In case 20, a provider requested a neurosurgery consultation, but the consultation was not scheduled until 30 days later.
- In case 22, a patient was supposed to see an ophthalmologist after cataract surgery but was rescheduled twice before being seen over two months later.
- In case 56, a provider requested follow-up with several specialists, but the staff did not ensure that the specialty appointments occurred.

Follow-Up After Specialty Service

Compliance testing scores showed patients often did not have access to providers after specialty consultations (MIT 1.008, 31.7%). Case review also found access issues; clinicians found four deficiencies regarding access to providers after specialty consultations in case 21.

In case 21, a patient was seen by an ophthalmologist twice. A nurse ordered a provider follow-up appointment, but the patient was not seen.

13. Deficiencies occurred in cases 3, 18, 20, 22, 25, and 56. Significant deficiencies occurred in cases 20, 22, and 56.

Later in this case, a nurse requested a provider follow-up for the patient after a high-priority specialty service, but the provider did not see the patient due to COVID-19 guidelines. Clinically, the provider should have seen the patient.

Follow-Up After Hospitalization

SATF did not always ensure providers saw patients after hospitalizations. Compliance testing scores were low (MIT 1.007, 65.2%). Case reviewers examined nine cases in which patients returned from the hospital and found two deficiencies. One deficiency was significant in the following case:

- In case 21, a patient returned from the hospital for dry gangrene and was not seen within five days by the primary care provider as requested.

Follow-Up After Urgent or Emergent Care (TTA)

Generally, patients had good access to providers after triage and treatment area (TTA) visits. However, case reviewers found two significant deficiencies in one case, case 23.

- In case 23, a patient was supposed to be seen by a provider after two separate visits to the TTA for seizures, but neither provider follow-up occurred. The patient should have been seen by his primary care provider based on the diagnosis. The provider documented that appointments were canceled due to the COVID-19 guidelines to minimize encounters.

Follow-Up After Transferring Into the Institution

Access to care for patients who have recently transferred into the institution was mixed. Compliance testing showed poor access to intake appointments for newly arrived patients (MIT 1.002, 32.0%). Case reviewers did not find any deficiencies in this area; however, we only reviewed three cases in which patients transferred from another institution.

Clinician On-Site Inspection

Case review clinicians discussed deficiencies with the supervisor in charge of scheduling as well as with nursing and provider leadership. At the time of the on-site inspection, an outbreak of COVID-19 was occurring at SATF. Many provider appointments and specialty appointments were canceled and had to be rescheduled due to the pandemic. Medical leadership stated appointments were rescheduled to comply with CCHCS guidelines to minimize unnecessary encounters. Medical leadership emphasized that providers were expected to review the medical record carefully to ensure they saw patients who needed to be seen.

Nurses on yards reported they were directed to only see patients from sick calls that were urgent or emergent. Several nurses mentioned they evaluated every sick call patient, beyond the minimum policy requirements, because they felt the need to provide care to their patients. In addition, care coordinators were left with the responsibility of prioritizing backlogged patients who required care such as wound care, blood pressure checks, EKGs, and diabetic education. Care coordinators on-site stated they had a backlog of 25 to 50 patients in one of their yard clinics.

While on-site, we observed that some nurses had already documented the plan of care for sick calls before assessing the patients. We are concerned about this pattern of practice at SATF.

Compliance On-Site Inspection

We visited six housing units and found only three had both CDCR Form 7362 available and an existing system to reorder the forms (MIT 1.101, 50.0%).

Recommendations

- Medical leadership should remind providers to complete a thorough and complete review of patients' medical records before deferring appointments, and to only defer those that do not pose an increased medical risk.
- Medical leadership should determine the cause of challenges in the timely provision of chronic care follow-up appointments with providers, nurse-to-provider referrals, specialty appointments and follow-up specialty appointments and implement remedial measures as appropriate.
- Medical leadership should ensure sufficient patient health care service request forms are available.
- Nursing leadership should review the pattern of populating treatments plans before seeing patients and implement remedial measures as appropriate.

Compliance Testing Results

Table 6. Access to Care

	Scored Answer			
Compliance Questions	**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) *	8	17	0	32.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	8	17	0	32.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	39	1	0	97.5%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	37	2	1	94.9%
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) *	1	9	30	10.0%
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) *	0	1	39	0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	15	8	2	65.2%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	13	28	4	31.7%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	3	0	50.0%
			Overall percentage (MIT 1): **45.9%**	

* 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) *	8	1	0	88.9%
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) *,†	0	0	9	N/A
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) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	7	5	3	58.3%
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) *	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	5	1	9	83.3%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	3	4	8	42.9%

* 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.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's ability to timely complete radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's ability to timely complete and review stat (immediate) laboratory tests.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate **(44.7%)**

Results Overview

SATF performed poorly in completing and retrieving diagnostic tests. Compliance testing revealed poor completion of X-rays, laboratory tests, and stat laboratory tests. Case review found acceptable performance in the completion of routine laboratory tests. The timeliness of completing and retrieving stat laboratory tests and the retrieval of pathology results were poor in compliance testing, while case review only observed one stat laboratory test that was not retrieved timely. Compliance testing showed mixed performance with heath information management: there were good scores in radiology, routine laboratory tests, and pathology retrieval, but poor scores for stat laboratory tests and pathology notifications. Case review identified urine culture results that did not populate or get scanned into the EHRS, which may have caused a preventable hospitalization. Providers did not consistently endorse diagnostic reports timely or routinely and did not always include all elements required in a patient notification letter. This is further discussed in the **Provider Performance** indicator. Because both compliance testing and case review analysis found inadequate ratings, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 113 diagnostic events and found 62 deficiencies, of which 13 were significant. Of those 62 deficiencies, we found 49 related to health information management and four pertaining to the completion of diagnostic tests.[14] Of the 49 health information management deficiencies, 13 were related to late or no retrieval of reports or late endorsement by providers.[15] For health information management, we considered test reports that were never retrieved or reviewed to be as severe of a problem as tests that were never performed.

Test Completion

Compliance testing showed poor performance in the completion of X-rays (MIT 2.001, 60.0%), laboratory tests (MIT 2.004, 60.0%), and stat laboratory tests (2.007, zero). Alternatively, case reviewers only found four deficiencies related to test completion.

14. Diagnostic tests were performed late in cases 10, 14, and 25.

15. Diagnostic reports were late or not retrieved in cases 4, 20, and 56. Diagnostic reports were signed late in cases 12, 15, 25, and 57.

- In case 25, laboratory tests were collected 15 days after the requested date.
- In case 10, a provider requested that a blood test be done the same day, but it was performed two days later. On-site, the supervisor stated the provider should have ordered the test stat instead of routine. As a result, the order was scheduled for two days later.
- In case 14, a provider ordered a test to be completed by a certain date (four days after the order), but it was not performed until five days after the specified date. On-site, the institution reported that because the order was routine, staff had 14 days to complete the laboratory test.

Health Information Management

Compliance testing showed that health information management performance in diagnostic services was mixed. Although providers generally reviewed X-rays (MIT 2.002, 90.0%), routine laboratory tests (MIT 2.005, 100%), and pathology laboratory tests (MIT 2.011, 83.3%) timely, they did not send patient notification letters for pathology reports (MIT 2.012, zero). Nurses did not notify providers of stat laboratory test results (MIT 2.008, 16.7%) and the institution did not retrieve pathology results timely (MIT 2.010, 50.0%). Case reviewers analyzed 113 diagnostic events and identified 49 health information management deficiencies, which made up over 40 percent of the events. Most of the deficiencies (36 out of 49) were incomplete patient notification letters.[16] However, we identified late or no retrieval of test results in cases 4, 20, and 56, with most of the deficiencies due to urine culture results not populating in the electronic health record system (EHRS). These were very important test results, as they help guide therapy.

- In case 20, urine culture results and antibiotic resistance and susceptibilities were not scanned into the EHRS. On-site, the supervisor agreed that these results were not in the system. This was important because the bacteria were resistant to the antibiotic (Bactrim) the patient was taking. The patient was subsequently hospitalized for the urine infection. Had the results been available to the providers, the providers could have changed the antibiotics and the patient may have avoided the hospitalization. On two other occasions in case 20, the patient did not have a stat urinalysis and a urine culture result in the EHRS. On-site, the supervisor agreed these results were not in the system.
- In case 56, urine culture results were not in the EHRS. The results were available in the laboratory web portal.

16. Deficiencies in patient notification letters occurred in cases 3, 4, 10, 11, 12, 14, 15, 17, 24, and 25.

Case reviewers only reviewed one stat laboratory test result and there was no evidence it was retrieved timely. We did not review any pathology results.

Clinician On-Site Inspection

We discussed deficiencies with the supervisor who managed scheduling, laboratory tests, and specialty services. We asked about the delays in test completion and the supervisor explained that because the laboratory tests were ordered routine, the laboratory had 14 days to complete the test despite the provider's request for a time-sensitive test. The supervisor agreed the urine culture could not be found in the results of the several cases that we discussed.

During our on-site inspection, we interviewed medical leadership and providers regarding the missing urine culture results. We discuss this issue further in the **Health Information Management** indicator.

Recommendations

- Laboratory supervisors should review the process of obtaining urine culture results and ensure the results are in the EHRS.
- Medical leadership should determine the cause of untimely radiology, laboratory, and pathology services and implement remedial measures as appropriate.
- Medical leadership should determine the cause of challenges in the endorsement of laboratory results and implement remedial measures as appropriate to ensure the results are endorsed within required time frames.
- Medical leadership should determine the cause of the untimely receipt of pathology reports and implement remedial measures as appropriate.
- Nursing leadership should determine the cause of the untimely notification of stat laboratory test results to providers and implement remedial measures as appropriate.
- The department should consider developing and implementing a patient results letter template for laboratory, radiology, and pathology results that autopopulates with all elements required per CCHCS policy.

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) *	6	4	0	60.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	9	1	0	90.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	1	9	0	10.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	6	4	0	60.0%
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)	0	10	0	0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	0	6	0	0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008) *	1	5	0	16.7%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	4	2	0	66.7%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	5	5	0	50.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	5	1	4	83.3%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	6	4	0%
				Overall percentage (MIT 2): **44.7%**

* 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.

Emergency Services

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score **(N/A)**

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; no compliance testing was performed for this indicator.

Results Overview

SATF delivered good emergency care. Similar to Cycle 5, nursing staff responded promptly to emergent events and provided appropriate care. However, OIG clinicians identified deficiencies due to incomplete nursing assessments and documentation. In addition, in our clinical review of emergent events, we found deficiencies not identified by staff at the institution. Most of these deficiencies were minor and did not affect patient care. The OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 56 urgent and emergent events and found 32 emergency care deficiencies. Of these 32 deficiencies, six were significant.[17]

Emergency Medical Response

SATF responded promptly to emergencies throughout the institution. Staff timely initiated CPR, activated emergency medical services, and notified TTA staff of emergent events. However, we identified an opportunity for improvement similar to what we found in Cycle 5:

- In case 9, institutional staff delayed calling 9-1-1 by 18 minutes for an unresponsive patient who was not breathing.

Provider Performance

SATF providers performed well in urgent and emergent situations, and in after-hours care. They made accurate diagnoses and completed documentation, with the following exception:

- In case 23, a provider on call did not document a progress note after discussing the patient's altered mental state with the TTA RN. Later in this case, a TTA provider did not perform a

17. Deficiencies occurred in cases 1, 4, 5, 6, 7, 8, 9, 16, 20, 22 and 23. Cases 4, 9, and 23 had significant deficiencies.

neurological examination of a patient with suspected seizure activity before sending him back to housing.

Nursing Performance

SATF nurses generally provided appropriate assessments and interventions. They recognized opioid overdoses when they occurred and implemented a nursing overdose protocol. However, our clinicians found deficiencies in the following nursing assessments:

- In case 4, a patient complained of chest pain to the clinic licensed vocational nurse (LVN). The clinic nurse did not immediately notify the TTA.
- In case 23, a TTA nurse did not notify a provider of a patient who had abnormally low blood sugar.

Nursing Documentation

Nursing documentation at the institution was acceptable. However, first responders and TTA nurses did not always document pertinent information. The following opportunity for improvement was identified:

- In case 5, nurses performed CPR and administered three doses of epinephrine and normal saline to a patient; however, they did not document the three doses on the patient's medication administration record.[18]

Emergency Medical Response Review Committee

The EMRRC met monthly and reviewed emergency response care within the required time frames. We found four minor deficiencies in the EMRRC reviews.[19]

Clinician On-Site Inspection

The TTA maintained three TTA bays, which provided sufficient space for emergency care. Medical staff had implemented a code blue crew, in which custody, medical, and support staff delegated responsibilities to ensure team members understood their roles during CPR.

During our clinical on-site inspection, many patients and staff at SATF had recently tested positive for COVID-19. Additionally, many more patients were in quarantine. The TTA designated an emergency bay for providing emergency care to patients who were positive for COVID-19.

Recommendations

We offer no specific recommendations for this indicator.

18. Epinephrine is a medication given during CPR to increase blood pressure and heart rate.

19. Minor deficiencies occurred in cases 1, 4, 5, and 8.

Health Information Management

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

Overall Rating ***Inadequate***

Case Review Rating ***Inadequate***

Compliance Score ***Adequate*** **(83.0%)**

Results Overview

The OIG found that hospital discharge records, urgent records, and emergent records were retrieved and scanned timely. However, specialty reports were not retrieved and scanned within policy time frames. Patient notification letters did not contain all elements required per CCHCS policy. In addition, diagnostic results did not always make it into the EHRS, specifically, urine cultures we observed in our case review. Staff did not identify this concern when we discussed it on-site, and providers did not routinely review the laboratory portal to search for results. This failure may alter therapeutic choices. Considering all aspects, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 814 events and found 93 deficiencies related to health information management. Of these 93 deficiencies, 17 were significant.[20] These deficiencies occurred in almost every detailed case we reviewed. Most of the deficiencies were due to incomplete patient notification letters.

Hospital Discharge Reports

SATF's management of hospital discharge reports was acceptable. Case review clinicians examined 13 off-site emergency department and hospital visits. SATF staff generally retrieved hospital records timely and scanned them into the medical record. However, we identified two late endorsements by the provider: one hospital report and one emergency department report. We also identified incomplete hospital records twice in case 22. Compliance testing also showed that SATF retrieved and scanned hospital discharge records timely (MIT 4.003, 90.0%); however, they did not always include a discharge summary with the hospital discharge records (MIT 4.005, 64.0%).

20. Health information management deficiencies occurred in cases 1, 2, 3, 4, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 24, 25, 56, 57, and 58.

- In case 1, a provider did not electronically endorse a hospital report until two and a half months after the report was retrieved. This was not within CCHCS policy.

Specialty Reports

SATF performed poorly in the management of specialty reports. Case review clinicians identified a pattern of either late retrieval and scanning, or lack of timely provider endorsements in 10 of the 23 applicable cases.[21] Compliance testing showed borderline poor retrieval of specialty reports (MIT 4.002, 73.3%) and low rates of provider endorsement for all specialty reports: high-priority (MIT 14.002, 53.3%), medium priority (MIT 14.005, 26.7%), and routine-priority (MIT 14.008, 45.5%). We also discuss these findings in the **Specialty Services** indicator.

- In case 11, the institution did not retrieve a dictated report for a spinal steroid injection performed at an off-site hospital. On-site, a supervisor acknowledged it was not retrieved and did not know why.
- In case 56, a wound care specialist did not document a note until six days after an encounter.

Diagnostic Reports

SATF performed poorly in managing diagnostic reports. Case review clinicians found 49 diagnostic health information management deficiencies, with a significant portion of them caused by incomplete patient notification letters. Most patient notification letters lacked one or more of the elements required by CCHCS policy.

We discovered that urine culture results were not available in the EHRS; we had to log into the laboratory's reporting portal to find the results. We identified the following significant deficiencies:

- In case 20, a urine culture result for a patient with a urine infection was not available in the EHRS. Because the provider did not check the urine culture result, which would have led the provider to change the antibiotic, the patient was hospitalized. Later in this case, another urine culture result was not available in the EHRS. On-site, the diagnostics supervisor agreed the results were not there and did not know why.
- In case 20, a stat urinalysis was not available in the EHRS. On-site, the supervisor was also unable to find it.
- In case 56, a urine culture result was not in the EHRS.

Compliance testing showed that notification of stat laboratory tests and communication of pathology results were poor (MIT 2.008, 16.7% and

21. Deficiencies related to the management of specialty reports were identified in cases 2, 4, 11, 12, 20, 21, 25, 56, 57, and 58.

MIT 2.012, zero, respectively). However, review of pathology reports was fair (MIT 2.011, 83.3%). Please refer to the **Diagnostic Services** indicator for further details about diagnostics.

Urgent and Emergent Records

SATF performed well in managing urgent and emergent medical records. OIG clinicians reviewed 56 emergency care events and found that SATF nurses effectively recorded these events. In addition, providers generally recorded their emergency care, including off-site telephone encounters, sufficiently. We did not identify any health information management deficiencies in this area.

Scanning Performance

Scanning performance at SATF was very good: case review clinicians reviewed over 800 encounters and identified only two mislabeled, misfiled, or late records. Compliance testing showed very good scanning, labeling, and filing performance (MIT 4.004, 87.5%).

Clinician On-Site Inspection

We discussed health information management processes with health information management supervisors, nurses, and providers and found they were unaware that urine culture results were not in the EHRS. Staff erroneously assumed the information would autopopulate into the medical record. One chief physician and surgeon only knew to check the laboratory company's web portal because of his experience at a women's prison; he mentioned he had to log into the laboratory web portal to access pap smear results because they were not available in the EHRS.

Recommendations

- The department should review how the laboratory's results populate into the EHRS to ensure timely and accurate availability of culture results.
- Medical leadership should consider requesting provider access and training providers to review the laboratory's web reporting portal. In addition, leadership should consider assigning staff to track all laboratory test results to ensure the results are reported in the EHRS.
- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required by CCHCS policy.

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	20	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	22	8	15	73.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	18	2	0	90.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	21	3	0	87.5%
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) *	16	9	0	64.0%
Overall percentage (MIT 4): **83.0%**				

* 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 %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	9	1	0	90.0%
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 provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008)*	1	5	0	16.7%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	5	5	0	50.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	5	1	4	83.3%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	6	4	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) *	8	7	0	53.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	4	11	0	26.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	5	6	4	45.5%

* 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
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(57.1%)

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 do not rate this indicator.

Compliance Testing Results

Outdoor Waiting Areas

We inspected outdoor patient waiting areas in SATF. Construction was continuing during our inspection. At the time of our on-site inspection, the outdoor area had a canopy to protect patients from inclement weather (see Photo 1, below). However, there was no seating available for patients waiting for their appointments. Custody staff reported they only escort two patients at a time to prevent overcrowding and to maintain safe distance during the pandemic. During inclement weather, custody staff escort patients to an indoor waiting area close to the clinic.

Photo 1. Outdoor waiting area in G Main Clinic (photographed on November 17, 2020).

Indoor Waiting Areas

We inspected SATF's indoor patient waiting areas. Health care and custody staff reported the existing indoor waiting areas had sufficient seating capacity that provided patients with protection from inclement weather (see Photo 2, right). Custody staff reported they brought a few patients at a time to prevent overcrowding the indoor waiting areas and to maintain safe distance during the pandemic. During our inspection, we did not observe patients waiting outside for their clinic appointments. All patients sat inside.

Photo 2. Indoor waiting area (photographed on November 18, 2020).

Photo 3. Examination room configuration did not allow patients to lie fully extended without obstruction (photographed on November 18, 2020).

Clinic Environment

All clinic environments were sufficiently conducive for medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT5.109, 100%).

Of the 12 clinics we observed, eight contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 66.7%). The remaining four clinics had one or more of the following deficiencies: examination rooms were unnecessarily cluttered and lacked adequate space (some rooms were smaller than the recommended 100 square feet); rooms had unsecured confidential medical records; and the examination table's placement did not allow patients to lie fully extended without obstruction (see Photo 3, above).

Clinic Supplies

Three of the 12 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 25.0%). We found one or more of the following deficiencies in nine clinics: expired medical supplies, unidentified medical supplies, disorganized medical supplies, compromised sterile medical supply packaging, cleaning materials stored with medical supplies, staff members' personal items and food stored with medical supplies, and medical supplies stored directly on the floor (see Photos 4, right; 5, below; and 6, next page).

Photo 4. Expired medical supplies dated August 2020 (photographed on November 18, 2020).

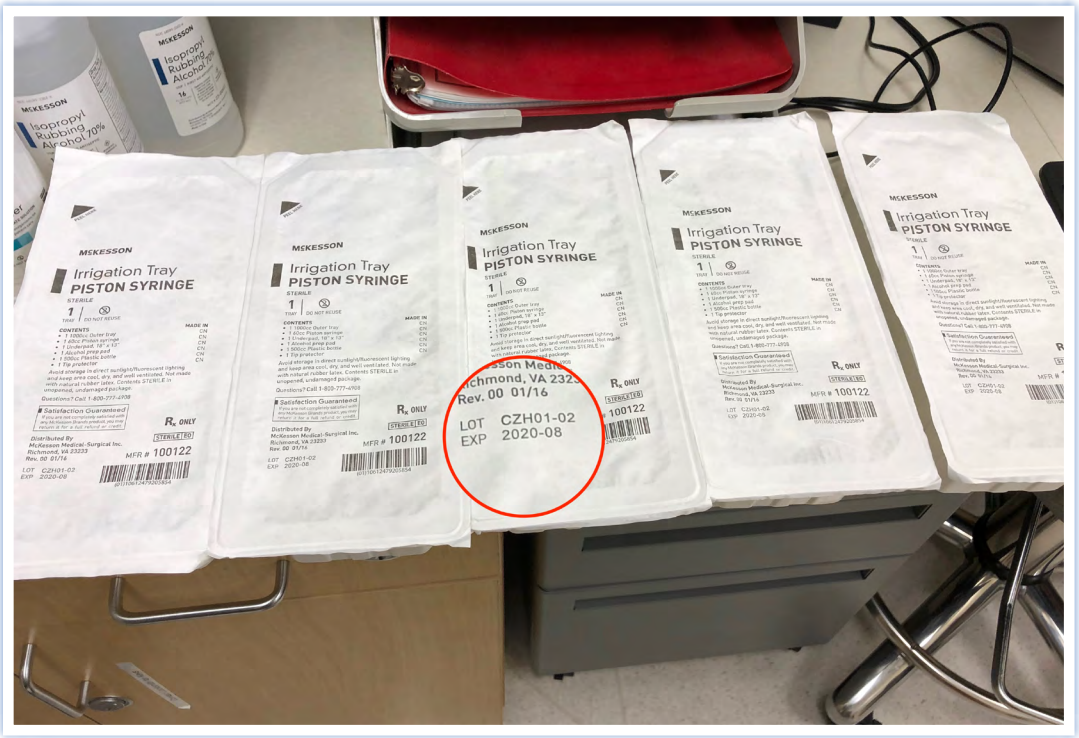


Photo 5. Expired medical supplies dated August 2020 (photographed on November 20, 2020).

Photo 6. Staff's personal items and food stored in the medical supply storage cabinet location (photographed on November 19, 2020).

Six of the 12 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 50.0%). The remaining six clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included hemoccult cards, a peak flow meter, and examination table disposable paper. The staff had not properly calibrated a weight scale, an automated external defibrillator (AED), an automated vital sign machine, and a nebulization unit. We found a nonfunctional ophthalmoscope and an expired lubricating jelly. SATF had not properly logged the results of the defibrillator performance test or the AED checklist within the last 30 days.

We examined emergency medical response bags (EMRBs) to determine if they contained all essential items. We checked if staff inspected the bags daily and inventoried them monthly. Only three of the 10 EMRBs passed our test (MIT 5.111, 30.0%). We found one or more of the following deficiencies with seven EMRBs: staff failed to ensure the EMRBs' compartments were sealed and intact; staff either had not inventoried the EMRBs when seal tags were replaced or had not inventoried the EMRBs in the previous 30 days; EMRBs were missing one nonrebreather mask or a disposable Ambu bag at the time of inspection; an EMRB contained an expired glucometer quality control solution; staff did not perform daily glucometer quality control checks; and a Narcan medication stored in an EMRB was not in its original packaging.[22]

22. An Ambu bag, or a bag valve mask, is a squeezable bag, a one-way valve, and a face mask. It is also known as a manual resuscitator.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found several expired medical supplies (see Photo 7, below).

According to the chief executive officer (CEO), the institution did not have any concerns about the medical supplies process. Health care managers and medical warehouse managers expressed no concerns about the medical supply chain or their internal communication.

Photo 7. Expired medical supplies dated September 20, 2020 (photographed on November 16, 2020).

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected five of 12 clinics (MIT 5.101, 41.7%). In seven clinics, we found one or both of the following deficiencies: cleaning logs were not maintained and biohazardous waste was not emptied from the previous day.

Staff in nine of 11 clinics (MIT 5.102, 81.8%) properly sterilized or disinfected medical equipment. In two clinics, staff did not mention disinfecting the examination table as part of their daily start-up protocol.

We found operating sinks and hand hygiene supplies in the examination rooms in 10 of 12 clinics (MIT 5.103, 83.3%). The patient restrooms in two clinics either lacked antiseptic soap or disposable hand towels.

We observed patient encounters in six clinics. In four clinics, clinicians did not wash their hands before or after examining patients, before applying gloves, or before performing blood draws (MIT 5.104, 66.7%).

Health care staff in 10 of 12 applicable clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 83.3%). In one clinic, we found an overfilled sharps container. In another clinic, the examination room lacked a nonbiohazardous waste bin.

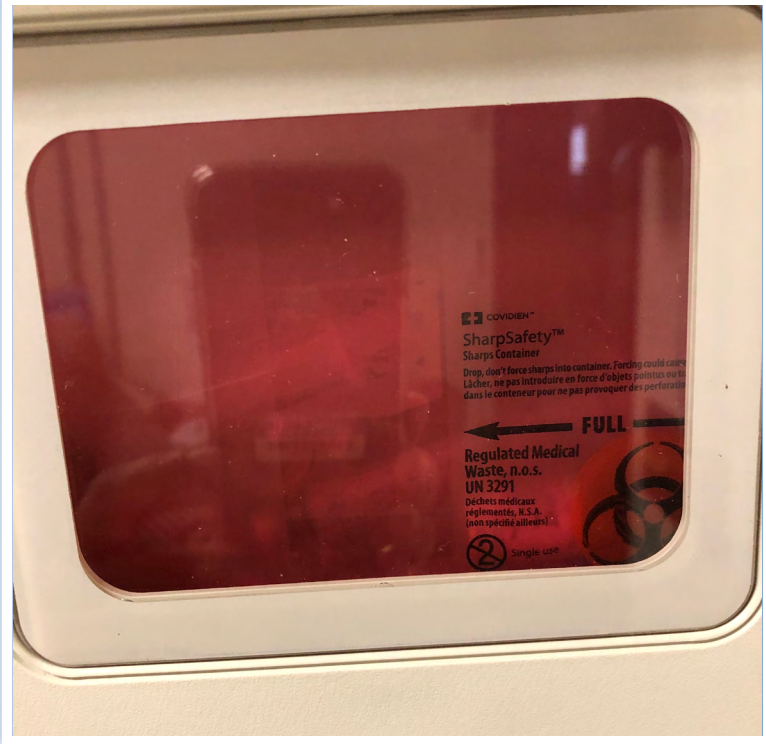


Photo 8. Expired medical supplies dated September 20, 2020 (photographed on November 16, 2020).

Physical Infrastructure

The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order and construction of the medical clinic at SATF did not hinder health care services.

At the time of our medical inspection, the institution's administrative team reported 10 concurrent ongoing Health Care Facility Improvement Program construction projects. However, all projects were delayed and placed on hold due to the COVID-19 pandemic (MIT 5.999).

Recommendations:

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should have each clinic nurse supervisor review the monthly EMRB logs to ensure the EMRBs are regularly inventoried and sealed. In addition, nursing leadership should implement random monthly inventory spot checks to ensure EMRBs contain all the medical supplies identified in the logs.
- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.

Compliance Testing Results

Table 11. Health Care Environment

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	5	7	0	41.7%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	9	2	1	81.8%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	10	2	0	83.3%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	4	2	6	66.7%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	2	0	83.3%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	3	9	0	25.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	6	6	0	50.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	12	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	8	4	0	66.7%
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)	3	7	2	30.0%
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): **57.1%**			

* 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
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(51.1%)

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, our 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, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed if staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the ability of staff to communicate vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed if 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 the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

SATF performed poorly in this indicator. For patients transferring into the institution, compliance testing revealed nurses did not thoroughly complete initial health screening forms, did not ensure medication continuity, and did not ensure patients were seen timely for preapproved specialty appointments. For the transfer-in process, OIG case review clinicians found that patients were seen in a timely manner and medications generally were delivered without interruption; however, they found minor opportunities for improvement in assessments and documentation. Case review clinicians identified significant deficiencies in reconciling medications and specialty referrals in the transfer-out process. Both compliance and case review found significant deficiencies when patients returned from the hospital. Considering all components of the transfer process, we rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 17 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 21 deficiencies, five of which were significant.[23]

Transfers In

For patients who transferred into SATF, compliance testing showed nursing staff did not complete initial health screenings or answer all screening questions within the required time frames (MIT 6.001, zero). Nursing staff did not include *fatigue* as a sign and symptom of TB

23. Deficiencies occurred in cases 1, 4, 12, 20, 21, 22, 23, 26, 28, 29, 30, 31, 56, and 57. Significant deficiencies occurred in cases 4, 20, 21, 23, 30, and 31.

during TB screenings, complete initial health screenings within the required time frame, and follow up with additional health care screening questions to elicit further explanation regarding mental illness or cocci.[24] However, case review clinicians found newly arrived patients were evaluated within the required time frames and usually received appropriate assessments. We identified minor deficiencies related to incomplete vital signs and one case in which a nurse did not follow up with additional health care screening questions regarding conditions requiring explanation.

For patients who transferred in from another departmental institution, medication delivery performance was mixed. Compliance testing found SATF did not administer or deliver medications without interruption (MIT 6.003, 53.3%). Analysis of the compliance data shows that about half of new arrival keep-on-person (KOP) medications were not administered timely or were not administered at all. However, case review clinicians did not find any deficiencies.

SATF scored low on compliance testing for patients transferring into SATF with preapproved specialty appointments (MIT 14.010, 40.0%). Our case review clinicians did not observe any transfer-in events involving preapproved specialty appointments.

Transfers Out

In the case review for patients transferring out of SATF, we identified two significant deficiencies:

- In case 30, a patient transferred out of SATF and the receiving and release (R&R) nurse did not notify the receiving institution of a pending telemedicine cardiology specialty referral. Ultimately, the patient did not see the cardiologist during the review period.
- In case 31, a patient transferred out of SATF without his prescribed medication, warfarin. However, the receiving institution reconciled the medications to ensure the continuity of the medication. The SATF pharmacist-in-charge acknowledged they should have filled this medication before the patient transferred.

SATF's transfer-out process was not observed by the compliance team because, due to the COVID-19 pandemic, no patients transferred out on the day of the OIG on-site inspection.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high-risk for lapses in care. These patients typically experienced severe illness or injury. They require more care and place strain on the institution's resources. Also, because the patients have complex medical

24. In April 2020, CCHCS reported that the symptom of *fatigue* was added into the EHRS powerform for TB-symptom monitoring.

issues, the successful transfer of health information is necessary for good quality care. Any lapse in the transfer process can result in serious consequences for these patients.

SATF did not perform well in providing follow-up appointments within the required time frames to patients returning from hospitalizations and emergency room visits (MIT 1.007, 65.2%). In some of the compliance samples, providers documented not completing face-to-face visits with patients due to COVID-19 quarantine and isolation.

Most discharge documents were scanned into patients' electronic health records within three calendar days of discharge (MIT 4.003, 90.0%). Compliance testing found providers did not routinely review and endorse documents in a timely manner (MIT 4.005, 64.0%). Clinicians identified two minor delays in obtaining a hospital discharge summary.

Compliance testing showed SATF had room for improvement in medication continuity and hospital discharge recommendations. Ordered medications were administered, made available, or delivered to patients within the required time frames 66.7 percent of the time (MIT, 7.003). Our clinicians identified the following significant deficiencies in medication continuity and in addressing hospital discharge recommendations:

- In case 20, a patient returned from a hospital admission and the antibiotic (Cephalexin) was not ordered as recommended. Subsequently, the patient missed two doses of the medication due to the medication not being available.
- In case 21, a patient returned from the hospital and a follow-up appointment with the provider was not scheduled within five calendar days. In addition, the recommended vascular surgery follow-up appointment was to be scheduled within two weeks; however, the appointment did not occur until almost four weeks later.
- In case 23, a provider endorsed hospital records but the recommended neurologist follow-up in one to two weeks was not ordered or scheduled.

Clinician On-Site Inspection

Our inspectors interviewed SATF nurses who were knowledgeable about the transfer-in process and the process of screening patients for COVID-19 prior to scheduled transfer-outs. However, the nurses did not complete face-to-face visits with patients within 24 hours of departure to ensure they had their KOP medications and durable medical equipment (DME). When patients arrived at the R&R for departure, nurses reviewed and documented whether the patients had KOP medications or DME. However, if the nurses identified missing medications, they did not allow themselves sufficient time to fulfill the policy requirement of filling the missing medications. During our inspection, we observed that nurses relied on custody staff to remind patients to bring their medications to the R&R rather than communicating with the patients directly.

Recommendations

- Nursing leadership should ensure R&R nurses complete a patient face-to-face visit 24 hours before the patient is transferred out of the institution.
- The department should consider developing and implementing an electronic alert to ensure nurses in receiving and release (R&R) properly complete initial screening questions and follow up as needed, that providers see patients in the time frame required based on the patient's clinical risk level, and that specialty appointments are scheduled within the required time frame.
- Nursing leadership should determine the cause of challenges in the provision of medications to newly arriving patients without interruption and implement remedial measures as appropriate.

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)	25	0	0	100%
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	7	10	53.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	N/A	N/A	N/A	N/A
				Overall percentage (MIT 6): **51.1%**

* 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

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	8	17	0	32.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	15	8	2	65.2%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	18	2	5	90.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	16	9	0	64.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	14	7	4	66.7%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	20	5	0	80.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	N/A	N/A	N/A	N/A
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	8	12	0	40.0%

* 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
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(67.7%)

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 the medication to the patient. When rating this indicator, the OIG strongly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Results Overview

SATF performed poorly in this indicator. Compliance testing showed that, compared with Cycle 5, SATF had more problems with the continuity of medications such as chronic care medications, newly prescribed medications, transfer medications, and specialized medical housing medications. In Cycle 6, they improved in ensuring patients received necessary medications after hospital discharge. Case reviewers found a pattern of patients not receiving their 30-day supply of keep-on-person (KOP) chronic care medications within the required time frame. Some patients did not have medications for more than 30 days. When analyzed together, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 125 encounters in 23 cases related to medications and found 28 medication management deficiencies, eight of which were significant.[25] We identified a pattern of poor chronic care medication continuity. The medication administration record (MAR) showed patients sometimes did not receive their chronic care medications without interruption. We identified other deficiencies that did not present a pattern in the cases we reviewed.

New Medication Prescriptions

Compliance testing showed most new medications were not available, delivered, or administered timely (MIT 7.002, 72.0%). However, OIG clinicians identified only one significant delay[26] in the delivery of newly prescribed medications in the following case:

- In case 21, a patient received his newly ordered postsurgical eye drops (ciprofloxacin, prednisolone, and ketorolac) a day late. These eye drops were needed to reduce postsurgical complications.

25. Deficiencies occurred in cases 4, 10, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 35, 42, 52, 53, 56, and 57. Cases 4, 10, 12, 17, 20, 21, 31, and 42 had significant deficiencies.

26. A significant deficiency occurred in case 21.

Chronic Medication Continuity

Chronic medication continuity at SATF was poor. Compliance testing found patients did not receive most of their chronic care medications within the required time frames (MIT 7.001, 4.6%). Case review clinicians also found a pattern of deficiencies in which chronic care medications were not administered continuously. We identified this pattern 19 times in eight unique cases out of the 23 cases we reviewed.[27]

- In case 4, a patient received his medication for nerve pain eight days late. The medication was not renewed in a timely manner when the prescription expired.
- In case 12, a patient with coronary artery disease did not receive his monthly KOP medication (aspirin) in May 2020.
- In case 20, a patient did not receive his monthly KOP chronic care medications for blood pressure (losartan and hydrochlorothiazide) in December 2019. The patient also did not receive his prostate medications (hydrochlorothiazide and tamsulosin) in May 2020. During the on-site inspection, the pharmacist-in-charge stated medications were dispensed; however, the chief nurse executive agreed that the medication administration record did not reflect that the patient received the medications.

Case reviewers also found problems with the administration of KOP medications. We identified seven deficiencies in the 23 detailed cases we reviewed.[28] Most patients received their KOP medications every 30 days; however, patients did not always receive refill medications at least one business day prior to the expiration date, as required by policy. The following are examples of deficiencies regarding KOP medications.

- In case 17, a patient submitted a sick call request for a nasal steroid spray for allergies. The MAR showed that the patient did not receive the medication until almost 30 days later.
- In case 22, a patient received his post-surgical eye drops one day late.
- In case 35, a patient did not receive his naproxen, which was requested by the sick call nurse.
- In case 42, a patient received his combination antifungal steroid ointment five days late.

Hospital Discharge Medications

SATF ensured patients received their recommended medications when they returned from an off-site hospital or emergency room. Our

27. Chronic care medications were not administered continuously in cases 4, 10, 12, 14, 16, 18, 20, and 52.

28. KOP medications were not administered correctly in cases 12, 17, 20, 21, 22, 35, and 42.

clinicians reviewed 10 hospital returns and only identified one significant deficiency.

- In case 20, a patient returned from the hospital with a diagnosis of a urinary tract infection. The patient missed the first two doses of his antibiotic because the medication was not available. While the pharmacist-in-charge stated that the patient likely received it, the medication administration record (MAR) did not show that the medication was administered.

Specialized Medical Housing Medications

Medication performance in specialized medical housing was poor. Case review clinicians evaluated two correctional treatment center (CTC) admissions and identified three deficiencies. Medications were not administered, as they were not available per the MAR. Compliance testing also found that when patients were admitted to the CTC, not all mediations were ordered, made available, or administered timely (MIT 13.004, 37.5%). In case review, we identified the following deficiency:

- In case 57, a provider ordered that a patient begin a course of doxycycline (an antibiotic) the same day the patient was admitted to the CTC; however, the patient missed a dose on the day of admission.

Transfer Medications

SATF had mixed performance with transfer medications. Compliance testing showed patients transferring into SATF did not receive most medications within the required time frame (MIT 6.003, 53.3%). Patients transferring within the institution received most medications timely (MIT 7.005, 80.0%). OIG clinicians evaluated eight transfer events and identified one transfer-out deficiency.

- In case 31, a patient transferred to another institution without his warfarin (a blood thinner). The pharmacist-in-charge acknowledged this was a pharmacy error.

Medication Administration

SATF nurses generally performed well in administering medications. Case review did not find any deficiencies with nurse-administered medications. Compliance testing showed how nurses administered and monitored patients taking TB medications. Nurses administered TB medications as prescribed (MIT 9.001, 100%). However, nurses did not monitor these patients as required by policy (MIT 9.002, zero).

Clinician On-Site Inspection

We met with the pharmacist, nurse managers, and nurses to discuss some of our findings. We found that medication nurses were knowledgeable

about the medication administration process. SATF has designated medication carts with both floor stock and patient-specific medications. Each yard has an Omnicell for controlled medications. In addition, Omnicells are located in the CTC, F Yard, and the TTA, and they are available for staff to use in obtaining antibiotics after hours. TTA nurses can pull medication from their Omnicell during business hours.

The pharmacist-in-charge explained that since April 2020, in response to the COVID-19 pandemic, the pharmacy did not accept any returned medication once it had been dispensed. The acting chief nurse executive stated the expectation was for nurses to obtain a signed refusal from patients before discarding medications. However, OIG clinicians learned that the direction was unclear on how long the medications should be kept before disposal. Interviews with the medication nurses on E and F Yards confirmed different retention schedules for medications. On one yard, nurses kept medications for two weeks, while some nurses on other yards kept medications for four weeks before disposing of them. There were no records of disposed medications.

Compliance Testing Results

Medication Practices and Storage Controls

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

SATF appropriately stored and secured nonnarcotic medications in nine of 11 clinic and medication line locations (MIT 7.102, 81.8%). In one location, an open medication bottle was found stored in the staff's desk drawer. In another location, nursing staff did not document several daily security checks in the crash cart log.

Staff kept medications protected from physical, chemical, and temperature contamination in five of the 11 clinic and medication line locations (MIT 7.103, 45.5%). In six locations, one or both of the following deficiencies occurred: staff did not store oral and topical medications separately and did not separate the medications from disinfectant wipes.

Staff successfully stored valid, unexpired medications in six of the 11 applicable medication line locations (MIT 7.104, 54.5%). In five locations, we found one or more of the following deficiencies: medication nurses did not initial or label multi-use medication as required by CCHCS policy, a medication with an expired pharmacy label was stored in the clinic, and an expired medication was stored in the clinic.

Nurses exercised proper hand hygiene and contamination control protocols in three of seven locations (MIT 7.105, 42.9%). Some nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in five of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 71.4%). In two locations, medication nurses did not maintain unissued medications in their original labeled packaging.

Staff in five of seven medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 71.4%). In one location, medication nurses did not reliably observe patients while they swallowed direct observation therapy medications. In another location, medication distribution did not occur within the time frame of one hour before or after the normal daily distribution time and the medication nurse did not disinfect the top of a previously opened insulin vial prior to withdrawing and administering the medication.

Pharmacy Protocols

SATF followed general security, organization, and cleanliness management 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 pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC did not correctly complete several medication area inspection checklists (CDCR Form 7477) and neglected to record names, signatures, or dates on several inventory records. These errors resulted in a score of zero percent in this test (MIT 7.111, zero).

We examined 25 medication error reports. The PIC timely or correctly processed 23 of these 25 reports (MIT 7.112, 92.0%). For one report, the PIC did not complete the medication error follow-up within the required time frame and completed the report seven days late. The other report had an error. More specifically, the date the medication error follow-up report was completed predated the date the error occurred and was reported through a CCHCS electronic health care incident report.

Nonscored Tests

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

The OIG interviewed patients in isolation units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Seven of 10 applicable patients we interviewed indicated they had access to their rescue medications (MIT 7.999). One patient reported he could not recall how long and why he did not have possession of his rescue inhaler and had notified medical staff.

Two other patients reported they did not notify custody or medical staff when they finished their rescue inhaler. We promptly notified the chief executive officer of this concern, and health care management immediately issued a replacement rescue inhaler to all three patients (MIT 7.999).

Recommendations

- Medical leadership should determine the cause of challenges related to chronic care medication continuity and implement remedial measures as appropriate.
- CCHCS should consider developing an EHRS notification to the patient care team if the keep-on-person (KOP) medications are not picked up by the patient before the medications are disposed of.

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) *	1	21	3	4.6%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	18	7	0	72.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	14	7	4	66.7%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	20	5	0	80.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	N/A	N/A	N/A	N/A
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	11	0	1	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	9	2	1	81.8%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	5	6	1	45.5%
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)	6	5	1	54.5%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	4	5	42.9%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	5	2	5	71.4%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	5	2	5	71.4%
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)	0	1	0	0%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	23	2	0	92.0%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **67.7%**

* 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	7	10	53.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	N/A	N/A	N/A	N/A
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	6	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) *	0	6	0	0
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	3	5	1	37.5%

* 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
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(60.4%)

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. Our case review clinicians do not rate this indicator.

Results Overview

SATF's performance was poor in preventive services. SATF faltered in monitoring patients who were taking prescribed TB medication, and screening patients annually for TB. These findings are set forth in the table below. We rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

Recommendations

- Medical leadership should determine the cause of challenges related to screening patients yearly for TB and implement remedial measures as appropriate.
- Medical leadership should remind nursing staff to perform weekly monitoring and address the symptoms of patients taking TB medications.

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)	6	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) †	0	6	0	0
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	11	14	0	44.0%
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)	25	0	0	100%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	11	3	11	78.6%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	0	3	0	0
				Overall percentage (MIT 9): **60.4%**

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

† In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the electronic health record system (EHRS) powerform for tuberculosis (TB)-symptom monitoring.

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Nursing Performance

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

When summarizing 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

SATF nurses delivered poor nursing care. Compared to Cycle 5, they continued to see patients timely. Nursing performance in emergency care and specialized medical housing was adequate. However, the nurses continued to miss opportunities for improvement by not assessing patients adequately, intervening appropriately, and communicating abnormal findings to providers. Sick call performance was poor because nurses did not evaluate urgent patients timely or thoroughly. While these nursing deficiencies illustrated poor performance, they can be corrected with quality improvement strategies. We considered the overall quality of nursing care and rated this indicator ***inadequate.***

Case Review Results

We reviewed 200 nursing encounters in 51 cases. Of the nursing encounters we reviewed, 147 were in the outpatient setting. We identified 105 nursing performance deficiencies, 20 of which were significant.[29]

Nursing Assessment and Interventions

All phases of nursing care depend on the accurate and complete collection of information. When information is not well-documented, the overall care of the patient could be affected; for example, incorrect diagnoses and inappropriate treatment could occur as a result. Our clinicians reviewed cases in which vital signs were not completed or

29. Deficiencies occurred in cases 1, 2, 3, 4, 5, 6, 7, 8, 9, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 25, 26, 28, 29, 30, 33, 35, 37, 39, 41, 43, 44, 45, 46, 48, 49, 50, 51, 52, 56, 57, 58, and 59. Cases 4, 19, 20, 21, 22, 23, 25, 30, 37, 39, 45, 51, and 56 had significant deficiencies.

the patient's body was not examined appropriately for the patient's medical complaint.[30]

- In case 20, a nurse assessed a patient who submitted a sick call request for blood in his urine and requested to see a urology specialist. The nurse did not assess lung sounds and notify the provider of the patient's abnormally elevated heart rate and respiratory rate, and foul-smelling urine.
- In case 22, a nurse did not perform a complete vision assessment for a patient who had recently undergone cataract surgery and complained of vision changes and eye discharge.

Nursing Documentation

Proper nursing documentation enables the transmission of complete and accurate information among health care staff, which prevents lapses in care. Inconsistent and incomplete nursing documentation at SATF occurred primarily during outpatient clinic visits.[31]

Nursing Sick Call

The process for nursing sick call involves reviewing each sick call request and determining whether the patient's medical symptoms require urgent or routine evaluation. We reviewed 104 sick call requests, 25 of which resulted in face-to-face appointments with nurses. There were two areas that needed improvement: the timeliness of reviewing urgent sick call requests and the thoroughness of nursing assessments. Although SATF nurses timely reviewed sick call requests, they did not evaluate urgent patients timely.

- In case 16, a sick call nurse did not assess a patient the same day for complaints of chest pain and abdominal pain.
- In case 17, an RN reviewed a sick call request for a patient complaining of having a chest cough for two months, shortness of breath, feelings of drowning in the chest, and low energy levels. The RN did not assess the patient the same day for urgent symptoms.
- In case 20, a patient submitted a sick call request for blood in his urine. The following day, the patient submitted a second sick call request stating he was exhausted, and his skin was hot to the touch. A nurse reviewed the sick call requests; however, the patient was not seen for his urgent symptoms on either day.
- In case 22, a sick call nurse did not assess a patient the same day for a sick call request with complaints of back pain, blurred vision, eye redness, and eye discharge.

30. Cases 1, 20, 22, 23, 28, 35, 37, 44, 45, 46, 49, 51, 56, and 57.

31. Cases 1, 4, 5, 7, 8, 9, 13, 14,17, 18, 19, 20, 22, 23, 28, 29, 30, 33, 41,44, 49, and 56.

- In case 51, a sick call nurse did not assess a patient who submitted a sick call request for flu-like symptoms.

When nurses evaluated patients, they did not thoroughly assess them. The following cases demonstrate this type of deficiency.

- In case 4, a patient submitted a sick call request complaining of chest pain, productive cough, joint pain, and night sweats. The clinic LVN who saw the patient did not immediately notify the TTA RN of a patient reporting urgent symptoms.
- In case 20, a TTA nurse reviewed a sick call request with a complaint of headaches and a request of a blood pressure check. An RN directed an LVN to take vital signs but did not assess the patient timely.
- In case 22, a sick call nurse assessed a patient for worsening back pain and weakness. A nurse did not complete an assessment of the patient's nervous system and did not notify a provider or refer the patient to a provider for follow-up.

Care Management/Coordinator

The clinic RN saw patients for chronic care management appointments upon their transfer into the institution and for follow-up visits ordered by the provider. Care coordinators saw patients for blood pressure checks, wound care, annual TB screenings, vaccinations, and additional orders providers made for LVN follow-up. In our review of hospitalization cases, we found inadequate monitoring of chronic conditions in symptomatic or high-risk patients and inadequate patient education on disease processes and hospitalization prevention. The following is one example:

- In case 20, a high-risk patient with a catheter and a history of a neurogenic bladder was scheduled for weekly catheter changes. During these appointments, the clinic RN cleansed the site and completed the catheter changes. Had the RN performed a more detailed genitourinary assessment and completed a chronic conditions assessment, the patient's hospitalizations for urinary tract infections may have been prevented.

Wound Care

We reviewed four cases in which nurses provided wound care.[32] We generally found assessments were incomplete and wound care was not performed as ordered. Three of the four cases had 12 deficiencies[33] and two cases had significant deficiencies:[34]

32. Cases 3, 21, 22, and 56.
33. Cases 3, 22, and 56.
34. Cases 22 and 56.

- In case 22, a nurse assessed a patient complaining of new facial wounds with purulent drainage. The patient had an abnormally elevated temperature. The nurse did not complete a thorough assessment, document the wound care provided, provide education to the patient, or notify the provider to obtain new wound care orders.
- In case 56, nurses did not complete wound care as ordered on five occasions in one month during the review period. Nurses routinely documented a patient's skin was intact without abnormalities even though the patient had been receiving care on multiple open wounds.

Emergency Services

While there were opportunities for improvement in nursing performance and documentation, SATF nurses provided adequate emergency care. Specific details are provided in the **Emergency Services** indicator.

Hospital Returns

We reviewed seven cases in which nurses assessed patients returning from the hospital or emergency room.[35] We found nurses generally assessed patients appropriately returning from the hospital. We identified minor opportunities for improvement in documentation. More specific details are provided in the **Transfers** indicator.

Transfers

We reviewed eight cases[36] in which nurses assessed patients transferring in or out of the institution. Opportunities for improvement were identified in documentation, medication continuity, and notification of pending specialty appointments. More details are provided in the **Transfers** indicator.

Specialized Medical Housing

Correctional treatment center (CTC) nurses completed timely assessments and provided essential care. There were opportunities for improvement in wound care and documentation. More details are provided in the **Specialized Medical Housing** indicator.

Specialty Services

SATF nurses examined patients upon their return from off-site specialty appointments. We identified a small pattern of inappropriate provider follow-up appointments for high-priority appointments. This is detailed further in the **Specialty Services** indicator.

35. Cases 3, 4, 20, 21, 22, 23, and 57.
36. Cases 1, 3, 4, 26, 27, 28, 29, 30, and 31.

Medication Management

OIG clinicians examined 125 events involving medication management and administration. We identified a lack in the continuity of chronic care medication, but no deficiencies in nurse-administered medications. This is detailed further in the **Medication Management** indicator.

Clinician On-Site Inspection

The CTC had well-prepared huddles conducted by lead nurses. The huddles were conducted by phone and computer due to the COVID-19 pandemic guidelines. The primary care team discussed their regular patients, patients who went to the hospital, sick call requests, and upcoming patient COVID-19 testing. Care coordinators were familiar with care management, including patient education, TB screening, dressing changes, and COVID-19 screening. The clinic nurses reported they review 80 to 100 sick call requests per day.

Clinic staff reported they were adjusting to new guidelines due to the COVID-19 quarantine and isolation procedures. Despite nursing direction to only see urgent and emergent patients in their housing units, several nurses reported they reviewed all sick calls and evaluated patients the same day or the next business day. Patients with emergent symptoms were sent to the TTA. Nurses still felt obligated to see nonurgent patients who had symptoms. During our inspection, we observed a sick call request for a sore throat that was reviewed that morning. A nurse reviewed this request and gave it to the scheduler. However, the nurse documented throat lozenges were administered to the patient prior to the assessment of the patient. Documentation of the assessment and plans prior to the evaluation of the patient falls below medical standards of care.

Due to the COVID-19 pandemic, nurses completed triage assessments in the housing units. Nurses reported they did not always have privacy, accessible weight scales, and protocol medications to administer to patients. If patients required medications, nurses obtained phone orders from physicians and entered orders for the pharmacy to dispense the medications.

Clinic nursing staff reported they assessed newly arrived patients, patients requiring wound care, and post-surgical patients. However, the clinic nurses mentioned they did not understand the reconciliation process because the clinic providers were responsible for reconciling new arrival orders. The reconciliation process is discussed further in the **Transfers** indicator.

During our on-site inspection we observed the institution's response to the COVID-19 pandemic. Most staff and patients wore face masks and practiced social distancing. However, in several clinics we observed nurses eating in their workspaces. Custody staff limited the number of patients in the clinics to ensure social distancing and many on-site specialty clinics were closed except for the physical therapy and specialty telemedicine clinics. The institution was on COVID-19 precaution

restrictions, which limited patient movement. Registry staff were hired to assess and take vital signs of patients who were in isolation or quarantine. Abnormal vital signs were reported to the clinic RN.

Recommendations

- Nursing leadership should ensure nurses perform more detailed assessments and interventions at each high-risk chronic care patient visit.
- Nursing leadership should remind nurses to assess patients for sick call requests prior to writing an intervention plan on the sick call slip.
- Nursing leadership should remind nurses to triage urgent symptomatic sick call requests timely.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Provider Performance

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

Results Overview

SATF providers delivered poor care. They made errors in assessment by either not examining pertinent aspects of the patient or by ignoring patients' medical issues and superficially reviewing patients' records. Providers made questionable decisions and did not always order appropriate follow-ups. SATF providers also did not document nursing co-consults or management decisions and did not notify patients of their laboratory test results. However, providers performed adequately in emergency care and exhibited good provider continuity. Overall, SATF received an ***inadequate*** rating for this indicator.

Case Review Results

In our inspection, we reviewed 120 provider encounters and found a total of 88 deficiencies.[37] Of these, 40 were significant. In addition, OIG clinicians examined the quality of care in 23 comprehensive case reviews. Of these 23 cases, 15 were adequate and eight were inadequate. We considered the COVID-19 pandemic and the guidelines that were implemented in our assessment.

Assessment and Decision-Making

SATF providers did not always examine patients according to their medical complaints and sometimes ignored their medical conditions. We identified these problems in 14 unique occurrences in 11 of the 20 detailed cases we reviewed.[38] This demonstrated a significant pattern.

- In case 15, a provider saw a hepatitis C patient for a chronic care appointment after the patient received colon cancer treatment; however, the provider did not follow the oncologist's recommendations for colon cancer surveillance and did not

37. Provider deficiencies occurred in cases 1, 2, 3, 4, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 34, 36, 52, 54, 56, 57, and 58. We found significant deficiencies in cases 4, 12, 13, 15, 17, 20, 21, 22, 23, 24, 25, and 56.

38. Providers did not examine patients appropriately in cases 1, 2, 4, 11, 14, 15, 18, 20, 22, 23, and 25.

follow the hepatitis C guidelines to consider any tests necessary for evaluating further treatment.[39]

- In case 23, a provider did not assess a patient for possible seizures following a TTA encounter and rescheduled the patient six months later. The provider should have seen the patient to determine the likelihood of seizures and whether the patient needed further diagnostic testing or therapy. A follow-up in six months was inappropriate.
- In case 25, a provider saw a patient for a follow-up after a urology specialist appointment and noted that the specialist did not receive the patient's kidney imaging studies, which were necessary to evaluate the patient for a possible bladder mass. The provider did not notify SATF's specialty department to ensure the images were sent to the specialist. Later in the case, the urologist recommended the patient see a nephrology specialist. However, the provider did not order a nephrology consultation for the patient until the urologist asked a second time. Fortunately, the patient did not have a bladder mass; however, these delays fell below the standard of care.

We also identified deficiencies in which providers made questionable decisions; this occurred in 20 unique occurrences in nine of the 23 cases we reviewed.[40]

In cases 3 and 12, a provider did not follow the specialists' recommendations for follow-up and did not document why.

- In case 12, a nephrology specialist recommended that the patient return to see the specialist later. The reviewing provider did not follow this recommendation; however, a covering provider saw the patient and ordered the follow-up appointment with the specialist. The reviewing provider later canceled the follow-up without documenting the reason.
- In case 20, a provider canceled a nurse visit for suprapubic catheter care. There was no documentation as to why this visit was canceled. Fortunately, another nurse reordered the suprapubic catheter care a few days later. Also in this case, the provider was made aware of an abnormal urine test showing the possibility of a urinary tract infection; however, the provider did not repeat the test, obtain urine cultures, or see the patient.
- In case 22, a provider endorsed laboratory tests showing elevated liver test results, but did not notify the patient about the results or develop a plan to investigate the cause of the abnormalities.

39. On the web: **CCHCS Care Guide: Hepatitis C**.

40. Providers made questionable decisions in cases 3, 12, 13, 14, 20, 21, 22, 25, and 56.

We identified another pattern in which providers did not order appropriate follow-up.[41]

- In case 15, due to the COVID-19 pandemic, a provider did not see a patient, noting that the patient was stable and did not need to be seen for 90 days. This was inappropriate because the patient had a recent elevated diabetes test HgbA1c and elevated fingerstick blood sugars.
- In case 22, on several occasions, a provider did not order follow-up for a patient with ongoing abscesses. The patient was subsequently seen by the provider due to a hospital follow-up and a hunger strike. Otherwise, the provider would not have a scheduled follow-up for the abscesses.

Review of Records

SATF providers did not always review medical records carefully. We found six deficiencies in the cases we reviewed.[42] The review of medical records is an important part of providers' workloads, especially during the pandemic. Inadequate reviews when patients are seen less frequently can increase the risk of harm.

- In case 20, a provider saw a patient who showed no improvement from antibiotics for a urinary tract infection. The provider did an incomplete review of the medical records and did not identify that urine culture results were still pending in the EHRS. In addition, the provider did not check the laboratory reporting portal to identify that the culture results and sensitivities were already available. Had the provider reviewed the results, the appropriate antibiotic probably would have been ordered.
- In case 57, a provider did not reconcile a patient's morning insulin when the patient returned from the hospital. However, the insulin was reconciled by a correctional treatment center (CTC) provider four days later.

Emergency Care

In general, SATF providers appropriately managed patients in the TTA with urgent and emergent conditions. We found two deficiencies in case 23. In one deficiency, the provider-on-call did not document a telephone encounter with a TTA RN regarding a patient who required Narcan.[43] In the second deficiency, a provider did not perform a neurologic examination on a patient for possible seizures before releasing the patient back to the yard.

41. Providers did not order appropriate follow-up in cases 10, 14, 15, 18, and 22.
42. Poor review of records occurred three times in cases 14, 25, 57, and 20.
43. Narcan is an opioid antidote.

Chronic Care

In most instances, SATF providers appropriately managed their patients' chronic health conditions. In general, they effectively managed hepatitis C, asthma, and anticoagulation. However, we identified a pattern where providers did not effectively manage elevated blood sugars and did not order appropriate follow-ups for hypertension.

- On several occasions in case 13, nurses notified providers about abnormally high blood sugars, but the providers did not address the blood sugars.
- In case 13, a provider saw a diabetic patient; however, the provider did not address elevated blood sugar results and did not perform a diabetic foot examination when the patient complained of foot pain.
- In case 10, a provider evaluated a patient during a chronic care appointment and noted elevated blood pressure; however, the provider did not order a blood pressure recheck or follow-up.
- In case 18, a provider adjusted blood pressure medications but did not order a follow-up to ensure the dosage was adjusted appropriately or to ensure there were no side effects.

Specialty Services

In general, SATF providers appropriately referred patients for specialty consultation when needed; however, providers did not always follow specialists' recommendations, specifically for specialty follow-ups. We identified these deficiencies in cases 12, 21, and 25. Providers on-site stated the specialty follow-ups did not occur due to COVID-19 pandemic guidelines from headquarters and because the patients were stable. We discuss this further in the **Specialty Services** indicator.

Documentation Quality

SATF providers did not always document progress notes. We found cloned notes in cases 56, 57, and 58. We also found a pattern of lack of documentation in cases 25, 34, 36, 52, 54, 57, 58, and in the following:

- In case 17, a provider co-consulted with a nurse but did not document a progress note.
- On several occasions in case 20, a provider ordered laboratory tests and antibiotics but did not document the reasons for these orders.
- In case 23, a provider did not document a co-consult with a nurse.

Patient Notification Letter

SATF providers did not always send patient notification letters to patients. When they did, the letters did not always contain the four elements required by policy. After providers interpret laboratory results, they are responsible for notifying patients of the laboratory results and of the necessary next steps. This is a widespread problem, as we found this type of deficiency in 18 of the 23 detailed cases we reviewed.[44]

Provider Continuity

Generally, SATF offered good provider continuity. Providers were assigned to specified clinics and to specialized medical housing units to ensure continuity of care. We did not identify any issues related to provider continuity.

Clinician On-Site Inspection

We discussed deficiencies with providers and medical leadership. They acknowledged the COVID-19 pandemic impacted provider availability and may have altered the usual quality of care. Several providers mentioned they were told to only see patients for urgent and emergent symptoms. Medical leadership reported that they counseled their providers to be careful about rescheduling appointments more than once. They recognized that rescheduling a low-priority appointment may cause a high-priority encounter the next time. Leadership also expressed their expectation that providers document all co-consults and send patient notification letters per policy. Leadership was unaware that culture results and pathology reports did not always populate into the EHRS.

Providers were complimentary toward their leadership. They indicated their leadership provided firm and fair guidance. Providers received timely and appropriate feedback. Providers voiced they had good collegiality with each other and good working relationships with nursing and custody staff. Despite the COVID-19 pandemic, morale was generally high during our on-site inspection.

Recommendations

- Medical leadership should ensure every provider has access to the web laboratory portal (Care 360) to review culture results or pathology results, as those results do not populate into the EHRS.
- Medical leadership should remind providers to fully document co-consults with nurses in the EHRS.

44. Providers did not send letters in cases 4, 12, 14, 15, 17, 20, 21, 22, 23, 24, and 25.

Specialized Medical Housing

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Adequate*** **(81.6%)**

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. SATF's specialized medical housing is a correctional treatment center (CTC). Our clinicians focused on medical staff's ability to assess, monitor, and intervene for medically complex patients requiring close medical supervision. Inspectors evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff's ability to respond promptly when patients' conditions deteriorated. Our clinicians looked for good communication when staff consulted one another while providing continuity of care. Our clinicians also interpreted relevant compliance results and incorporated them into this indicator.

Results Overview

SATF delivered good patient care in the CTC. The institution performed well with case review and compliance testing by providing good, timely assessments. Nurses provided appropriate admission assessments, administered medication timely, and provided appropriate wound care. We rated this indicator ***adequate***.

Case Review and Compliance Testing Results

The CTC is a 38-bed unit, with 18 beds designated for medical patients. At the time of our inspection, the medical beds were fully occupied. We reviewed three CTC cases, which included 34 provider events and 13 nursing events. Because of the volume of care that occurs in specialized medical housing units, each provider and nursing event represents up to one month of provider care and one week of nursing care. We identified 15 deficiencies, two of which were significant.[45]

Provider Performance

Case review clinicians examined 34 CTC provider encounters and noted six deficiencies in three cases. Only one deficiency was significant. Most of the minor deficiencies were due to cloned elements in progress notes. Compliance testing found that admission histories and physical examinations were performed completely and timely (MIT 13.002, 88.9%). Providers rounded at clinically appropriate intervals. Providers generally made sound medical decisions and plans. They documented well; however, they sometimes clone elements in progress notes, which may have led to some inaccurate documentation.

- In case 56, a provider performed rounds for a patient in the CTC but did not review or follow the wound care provider's recommendation for a vascular surgery consultation. The provider also cloned elements of previous progress notes, which led to inaccurate documentation.

45. Deficiencies occurred in cases 56, 57, and 58. Case 56 had two significant deficiencies.

Nursing Performance

CTC nurses provided adequate care, with timely assessments and appropriate interventions. Our compliance testing showed CTC nurses completed timely admission assessments (MIT 13.001, 100%). However, our clinicians identified opportunities to improve the consistency of assessment and wound care documentation as in the following example:

- In case 56, a wound care nurse did not perform wound care as ordered to a patient' left heel, left groin, and right groin. Furthermore, throughout the review period, there was a pattern of inconsistent skin assessment documentation. Even though wound care nurses completed wound care on multiple open wounds, a CTC nurse documented the skin was intact with no issues.

Nurses also ensured patients admitted to the CTC were educated regarding the use of the patient call system (MIT 13.101, 100%).

Medication Administration

Compliance findings showed patients did not receive their medications within the required time frames upon their admission to the CTC (MIT 13.004, 37.5%). Analysis of the compliance data revealed that important KOP medications (two inhalers for acute shortness of breath and one medication for chest pain) were not administered to three patients. In addition, other patients did not receive their medications on time on the day of admission. Our clinicians found one case in which a patient did not receive doses of two medications within the required time frame.

Clinician On-Site Inspection

The institution's CTC had 18 medical beds. At the time of our inspection, the medical beds were fully occupied.

Nursing staff were available in the CTC 24 hours a day. During the day, the CTC was staffed with two RNs, two LVNs and one certified nursing assistant (CNA). There was also a lead nurse responsible for making patient rounds with the CTC provider and assessing all admissions and discharges. On other shifts, the CTC was staffed with two to three RNs, one LVN, and one CNA.

Nursing staff reported that due to a shared ventilation system in the CTC, positive COVID-19 patients requiring a CTC bed were housed in a temporary medical housing unit until they received a negative COVID-19 test. Nursing staff also reported low employee morale due to low staffing levels and mandatory overtime during the COVID-19 pandemic. Although staff felt supported by their direct nursing supervisors, they did not feel as supported by nursing administration. In addition, nurses reported they received a negative response from leadership when they ordered personal protective equipment (PPE) more frequently than scheduled.

Recommendations

- Nursing leadership should determine the root cause of challenges in patients receiving all ordered medications within the required time frame and implement remedial measures as appropriate.
- Nursing leadership should consider ways to improve patient handoff between the CTC and the telemedicine nurse after wound care specialty consults.

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) *	9	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) *	8	1	0	88.9%
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) *,†	0	0	9	N/A
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) *	3	5	1	37.5%
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%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	0	0	1	N/A
				Overall percentage (MIT 13): **81.6%**

* 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. The 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.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
***Inadequate* (56.2%)**

Results Overview

SATF provided poor specialty services for their patients. Compliance testing revealed problems with access to specialty services, follow-ups after specialty consultations, and the management of specialty reports. Case reviewers also identified problems with access to specialty services, providers' review of specialty reports, and the timeliness of retrieving and scanning specialty reports. There were instances in which providers did not follow specialists' recommendations. We also identified a few deficiencies in which nurses did not order appropriate follow-up with the provider or send necessary medical information to the specialists. Taken together, SATF has an ***inadequate*** rating for this indicator.

Case Review and Compliance Testing Results

We reviewed 88 events related to specialty services; 69 were specialty consultations and procedures. We found 44 deficiencies in this category, 22 of which were significant.[46] In comparison to Cycle 5, SATF had fewer specialty events, but more deficiencies. The main problems were poor access to specialists, late provider endorsement of specialty reports, and late retrieval of specialty reports.

Access to Specialty Services

SATF performed poorly with access to specialists. With the exception of high-priority (MIT 14.001, 86.7%) referrals, compliance testing showed SATF did not provide good access to specialty services. Routine-priority (MIT 14.007, 66.7%) and medium-priority (MIT 14.004, 60.0%) specialty referrals as well as the continuity of specialty services after transfer into the institution (MIT 14.010, 40.0%) were poor. Case review also identified poor access, as we found 13 deficiencies in 22 relevant cases.[47] Only two of the deficiencies were related to rescheduling due to the COVID-19 pandemic.

- In case 20, a neurosurgery consultation was scheduled 30 days after the compliance date.

46. Specialty services deficiencies occurred in cases 2, 3, 4, 11, 12, 18, 20, 21, 22, 25, 56, 57, and 58. Significant specialty services deficiencies occurred in cases 2, 4, 11, 12, 20, 21, 22, 25, 57, and 58.

47. Deficiencies in access to specialty services occurred in cases 3, 18, 20, 21, 22, 25, and 56. Significant deficiencies occurred in cases 20, 32, and 56.

- In case 25, a patient was due for a urology follow-up; however, the visit did not occur until three months later due to limited movement during the COVID-19 pandemic.
- In case 56, a provider requested consultations with an infectious disease specialist, podiatrist, and vascular surgeon. However, these appointments did not occur within the requested time frames.

Provider Performance

In general, providers referred patients to the correct specialist within the appropriate time frames. However, provider follow-ups after specialty appointments did not always occur within policy time frames. Compliance testing showed that patients did not often see their providers or RNs promptly after specialty services (MIT 1.008, 31.7%). Case review identified a similar pattern in which follow-up with the primary care team did not occur within policy time frames. Case reviewers also found that providers did not always follow specialists' recommended follow-up interval.[48] This issue was discussed in the **Provider Performance** indicator.

- In case 21, on two occasions, provider follow-up after an ophthalmology appointment did not occur. Later in the same case, an RN scheduled a provider follow-up within 14 days instead of within five days following a high-priority specialty service, as required by CCHCS policy.
- In case 22, a provider follow-up occurred 10 days after the specialty appointment instead of five days as required by policy.

Providers did not always review specialty reports timely. This deficiency pattern was identified five times in three cases.[49] The following is an example:

- In case 12, a provider endorsed a nephrology specialty report seven days after it was available.

Nursing Performance

SATF nursing performance with specialty services was adequate. In general, nurses properly evaluated patients returning from off-site appointments, with one exception in case 20. There was a small pattern of inappropriate provider follow-up orders.[50] In one instance, a TTA nurse received an illegible consultation report but failed to contact the specialist for clarification. A specialty RN did not provide necessary background information to a specialist in cases 18 and 25. There was a pattern of incomplete assessments and documentation for patients

48. Providers did not implement a specialist's recommendation in cases 12, 21, and 25.
49. Late endorsements were found in cases 12 and 20, and several times in case 21.
50. Nurses ordered inappropriate provider follow-ups in cases 20, 21, and 22.

returning from specialty visits. However, these deficiencies were minor and did not affect patient care.

- In case 25, a urologist requested several urinary studies that were performed. However, a specialty RN did not send the reports to the specialist so he could make informed recommendations.
- In case 21, an RN scheduled a provider follow-up appointment for 14 days after a high-priority specialty service instead of the five calendar days required by CCHCS policy.

Health Information Management

Compliance testing found providers did not timely review specialty reports for routine-priority referrals (MIT 14.008, 45.5%), medium-priority referrals (MIT 14.005, 26.7%), and high-priority (MIT 14.002, 53.3%) referrals. In addition, specialty medical reports were not scanned into the EHRS in a timely manner (MIT 4.002, 73.3%). Case reviewers also found problems with the management of specialty reports.[51]

- In case 4, the institution retrieved two cardiology specialty reports one and two days late, respectively.
- In case 11, a patient received a lumbar epidural steroid injection at an off-site hospital. However, the report was not obtained, and the institution's staff did not know why this report was not retrieved.
- In case 58, the institution did not retrieve a neurosurgeon report and did not scan the report into the EHRS.

Clinician On-Site Inspection

We had a discussion with SATF managers, supervisors, providers, and utilization nursing staff about specialty referral management. Supervisors stated access to specialists was impacted by specialists canceling appointments and CCHCS guidelines about limited movement.[52] In addition, a telemedicine nurse reported that only emergent, essential, and wound care specialty appointments were scheduled since March 2020. When patients were placed in quarantine or isolation, the telemedicine nurse was not notified timely. Therefore, scheduled appointments were often canceled one to two days before the patient was to be seen. This contributed to a backlog in telemedicine appointments. Nursing supervisors managed the backlog. Most on-site specialty clinic appointments were delayed due to the COVID-19 pandemic.

51. Problems with the retrieval of records occurred in cases 2, 4, 11, 12, 20, 21, 25, 56, 57, and 58.

52. On the web: **COVID-19 and Seasonal Influenza: Interim Guidance for Health Care and Public Health Providers**.

Recommendations

- Institutional leadership should remind both providers and nurses to review specialty reports within the required time frames and implement remedial measures as appropriate.
- Medical leadership should determine the cause of the untimely provision of ordered specialty services and subsequent follow-up visits and implement remedial measures as appropriate.
- Medical leadership should determine the cause of challenges in notifying patients of specialty denials within the required time frame and implement remedial measures as appropriate.

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) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	7	5	3	58.3%
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) *	9	6	0	60.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	4	11	0	26.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	5	1	9	83.3%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	10	5	0	66.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	5	6	4	45.5%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	3	4	8	42.9%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	8	12	0	40.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	12	6	2	66.7%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	9	11	0	45.0%
				Overall percentage (MIT 14): **56.2%**

* 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) *, †	13	28	4	31.7%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	22	8	15	73.3%

* 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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(66.5%)

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined if the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors examined if the institution provided training and job performance reviews for its employees. They checked whether staff possessed current, valid professional licenses, certifications, and credentials. 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. 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.

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. Six unexpected (Level 1) deaths occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of the death. When the DRC completes the death review summary report, it must submit the report to the institution's chief executive officer within seven calendar days of completion. In our inspection, we found the DRC did not complete any death review reports promptly; the DRC finished six reports one to 35 days late and submitted them to the institution's CEO three to 28 days later (MIT 15.998).

Recommendations

The OIG offers no specific recommendations for this indicator.

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	0	1	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	5	1	0	83.3%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	11	1	0	91.7%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent, meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	2	2	0	50.0%
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' appealed 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)	9	1	0	90.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	0	10	0	0
Did physician managers complete provider clinical performance appraisals timely? (15.105)	11	0	0	100%
Did the providers maintain valid state medical licenses? (15.106)	13	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	1	1	1	50.0%
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)	0	1	0	0
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): **66.5%**			

* Effective March 2021, this test was for informational purposes only.

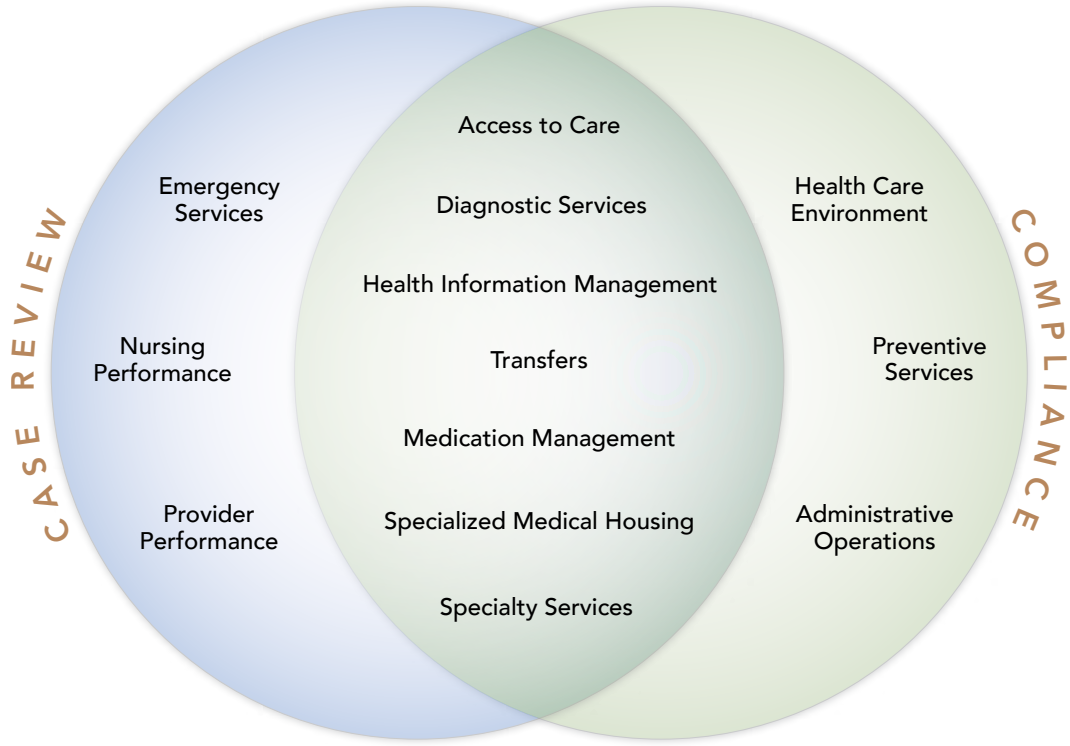
Source: The Office of the Inspector General medical inspection results.

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 SATF



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 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

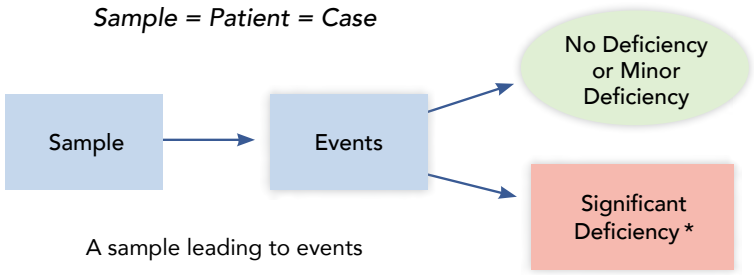
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

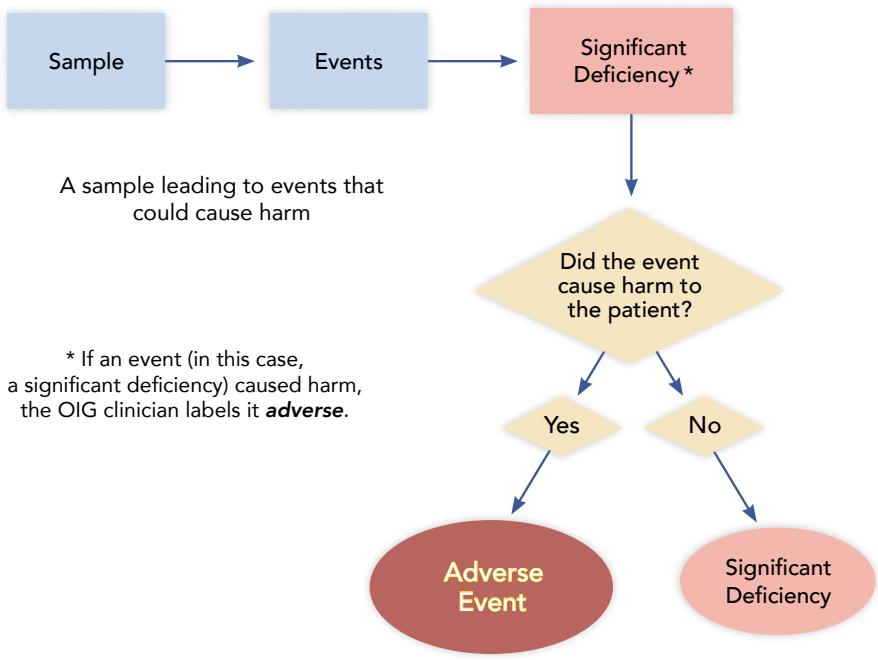
Figure A–2. Case Review Testing

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***.



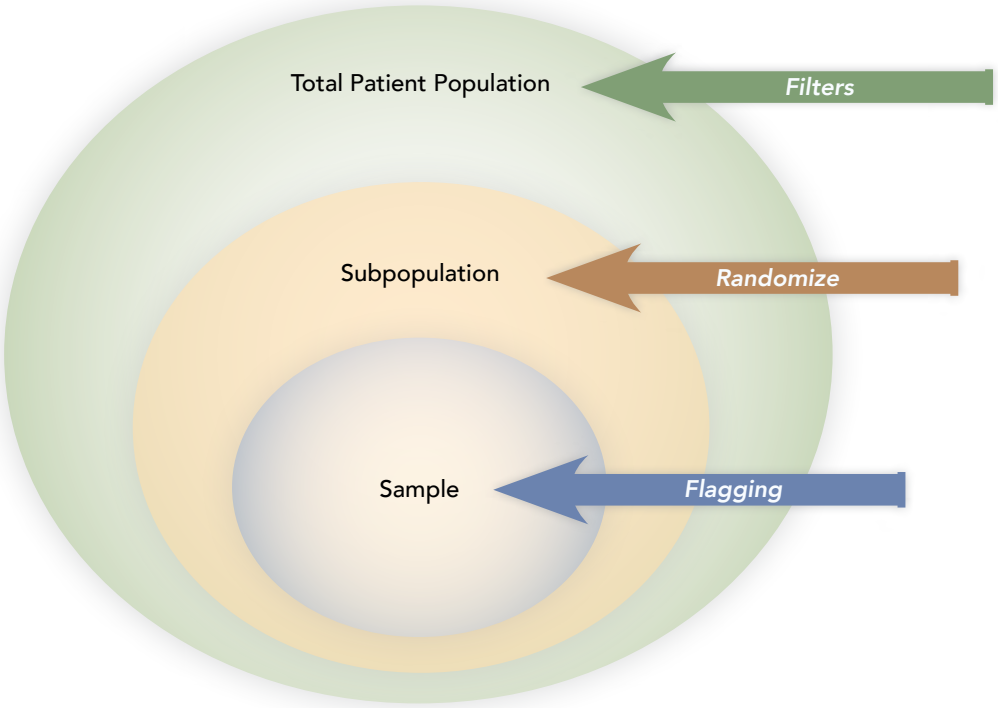
Source: The Office of the Inspector General medical inspection analysis.

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*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

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. SATF Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	24
Specialty Services	2
	58

Table B–2. SATF Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	3
Anticoagulation	5
Arthritis/Degenerative Joint Disease	3
Asthma	7
COPD	4
Cancer	1
Cardiovascular Disease	6
Chronic Kidney Disease	4
Chronic Pain	11
Cirrhosis/End-Stage Liver Disease	7
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	10
Gastroesophageal Reflux Disease	14
Hepatitis C	13
Hyperlipidemia	18
Hypertension	25
Mental Health	23
Migraine Headaches	3
Seizure Disorder	3
Sleep Apnea	3
Thyroid Disease	1
	168

Table B–3. SATF Case Review Events by Program

Diagnosis	Total
Diagnostic Services	116
Emergency Care	56
Hospitalization	26
Intrasystem Transfers In	12
Intrasystem Transfers Out	4
Not Specified	2
Outpatient Care	432
Specialized Medical Housing	62
Specialty Services	103
	813

Table B–4. Case Review Sample Summary

MD Reviews Detailed	23
MD Reviews Focused	1
RN Reviews Detailed	15
RN Reviews Focused	29
Total Reviews	68
Total Unique Cases	58
Overlapping Reviews (MD & RN)	10

Appendix C: Compliance Sampling Methodology

California Substance Abuse Treatment Facility and State Prison at Corcoran

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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	40	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	25	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	12	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	0	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See **Reception Center**
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	0	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	25	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	10	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	6	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary)	3	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	9	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MIT 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services				
MIT 14.010	Specialty Services Arrivals	20	Specialty Service Arrivals	• Arrived from (other departmental institution) • Date of transfer (3-9 months) • Randomize
MITs 14.011-012	Denials	20	InterQual	• Review date (3-9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	1	Adverse/sentinel events (ASE) report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	11	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	13	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	7	OIG summary log: deaths	• Between 35 business days & 12 months prior • Health Care Services death reviews

California Correctional Health Care Services' Response

July 13, 2021

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 Substance Abuse Treatment Facility (SATF) conducted from January to June 2020. California Correctional Health Care Services (CCHCS) acknowledges 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) 691-3557.

Sincerely,

Erin Hoppin Digitally signed by Erin Hoppin
Date: 2021.07.13 15:17:22 -07'00'

Erin Hoppin
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Richard Kirkland, Chief Deputy Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Jackie Clark, Deputy Director (A), Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Regional Health Care Executive, Region III, CCHCS
Regional Deputy Medical Executive, Region III, CCHCS
Regional Nursing Executive, Region III, CCHCS
Chief Executive Officer, SATF
Katherine Tebrock, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Misty Polasik, Staff Services Manager I, OIG

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

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Cycle 6
Medical Inspection Report

for

California Substance Abuse Treatment Facility and State Prison at Corcoran

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
September 2021

OIG