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Independent Prison Oversight

January 2022

Cycle 6

Medical Inspection Report

Central California Women's Facility

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Cover: Rod of Asclepius courtesy of Thomas Shafee

Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated 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 answer 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***.

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[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 (HEIDIS) 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 Central California Women's Facility (CCWF), the receiver had delegated this institution back to the department.

We completed our sixth inspection of CCWF, and this report presents our assessment of the health care provided at that institution during the inspection period between August 2020 to January 2021.[6] The data obtained for CCWF, and the on-site inspections occurred during the COVID-19 pandemic.[7]

Central California Women's Facility is located in Chowchilla, Madera County. California's largest female institution, CCWF is the only female prison designated as a reception center. In addition, the institution houses the only death row for women in California. The institution's medical clinics provide routine health care services. Patients also receive care at CCWF's on-site specialty clinic, and there is a separate clinic for patients in administrative segregation. The institution's medical staff screen arriving and departing patients at the receiving and release clinic (R&R) and also treat patients requiring urgent or emergent care at the treatment and triage area (TTA). California Correctional Health Care Services (CCHCS) has designated CCWF as an *intermediate* health care institution.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include noncardiopulmonary resuscitation (non-CPR) reviews between January 2020 and September 2020, death reviews between November 2019 and September 2020, diabetes reviews between August 2020 and February 2021, perinatal services reviews between February 2020 and January 2021, high-risk reviews between August 2020 and February 2021, specialty service reviews between August 2020 and February 2021, and RN sick call reviews between August 2020 and April 2021.

[7] As of October 10, 2021, the department's public tracker reports 81 percent of CCWF's incarcerated population is fully vaccinated, while 62 percent of CCWF's staff are fully vaccinated: www.Population COVID-19 Tracking - COVID-19 Information ca.gov.

Summary

We completed the Cycle 6 inspection of Central California Women's Facility (CCWF) in May 2021. OIG inspectors monitored the institution's medical care that occurred between August 2020 and January 2021.

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

Table 1. CCWF Summary Table

Health Care Indicators	Cycle 6 Case Review Rating	Cycle 6 Compliance Rating	Cycle 6 Overall Rating	Change Since Cycle 5
Access to Care	*Adequate*	*Adequate*	*Adequate*	↑
Diagnostic Services	*Adequate*	*Adequate*	*Adequate*	=
Emergency Services	*Inadequate*	*N/A*	*Inadequate*	=
Health Information Management	*Adequate*	*Proficient*	*Adequate*	↓
Health Care Environment	*N/A*	*Adequate*	*Adequate*	↑
Transfers	*Adequate*	*Inadequate*	*Adequate*	↑
Medication Management	*Inadequate*	*Inadequate*	*Inadequate*	=
Prenatal and Postpartum Care	*Proficient*	*Proficient*	*Proficient*	↑
Preventive Services	*N/A*	*Adequate*	*Adequate*	↓
Nursing Performance	*Adequate*	*N/A*	*Adequate*	↑
Provider Performance	*Adequate*	*N/A*	*Adequate*	↑
Reception Center	*Adequate*	*Adequate*	*Adequate*	↑
Specialized Medical Housing	*Adequate*	*Adequate*	*Adequate*	=
Specialty Services	*Adequate*	*Adequate*	*Adequate*	↑
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 437 patient records and 1,285 data points and used the data to answer 107 policy questions. In addition, we observed CCWF processes during an on-site inspection in April 2021. Table 2 below lists CCWF average scores from Cycles 4, 5, and 6.

Table 2. CCWF Policy Compliance Scores

Scoring Ranges

100%–85.0%	84.9%–75.0%	74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Cycle 4 Average Score	Cycle 5 Average Score	Cycle 6 Average Score
1	Access to Care	66.3%	83.2%	80.5%
2	Diagnostic Services	64.0%	76.7%	75.8%
4	Health Information Management	67.1%	93.0%	89.3%
5	Health Care Environment	84.1%	61.7%	79.6%
6	Transfers	69.0%	75.1%	61.1%
7	Medication Management	61.3%	73.9%	67.8%
8	Prenatal and Postpartum Care	71.4%	83.3%	100%
9	Preventive Services	74.2%	85.2%	76.8%
12	Reception Center	40.7%	72.5%	75.0%
13	Specialized Medical Housing	98.0%	95.0%	77.5%
14	Specialty Services	69.5%	89.6%	75.9%
15	Administrative Operations	69.0%*	81.4%	71.2%

* 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.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 48 cases, which contained 1,617 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection to verify their initial findings. The OIG physicians rated the quality of care for 26 comprehensive case reviews. Of these 26 cases, our physicians rated 23 ***adequate*** and three ***inadequate***. Our physicians did not identify any adverse events during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 15 health care indicators. Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the CCWF Summary Table.

In March 2021, the Health Care Services Master Registry showed that CCWF had a total population of 2,132. A breakdown of the medical risk level of the CCWF population as determined by the department is set forth in Table 3 below.[8]

Table 3. CCWF Master Registry Data as of March 2021

Medical Risk Level	Number of Patients	Percentage
High 1	149	7.0%
High 2	188	8.8%
Medium	1,142	53.6%
Low	653	30.6%
Total	**2,132**	**100.0%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 3-19-21.

[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, CCWF had one executive leadership position vacancy, zero primary care provider vacancies, 1.2 nursing supervisor vacancies, and 20 nursing staff vacancies.

Table 4. CCWF Health Care Staffing Resources as of March 2021

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	5	11.5	15.2	125.8	157.5
Filled by Civil Service	4	13.5	14	95.4	126.9
Vacant	1	0	1.2	20	22.2
Percentage Filled by Civil Service	80%	117.4%	92.1%	75.8%	80.6%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	1	0	14	15
Percentage Filled by Registry	0	8.7%	0	11.1%	9.5%
Total Filled Positions	4	14.5	14	109.4	141.9
Total Percentage Filled	**80.0%**	**126.1%**	**92.1%**	**87.0%**	**90.1%**
Appointments in Last 12 Months	1	3	6	36	46
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	1	9	10
Adjusted Total: Filled Positions	**4**	**14.5**	**13**	**100.4**	**131.9**
Adjusted Total: Percentage Filled	**80.0%**	**126.1%**	**85.5%**	**79.8%**	**83.7%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes 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 March 2021, 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]

Our inspectors did not find any adverse events at CCWF in the cases reviewed during the Cycle 6 inspection.

Case Review Results

OIG case reviewers assessed 12 of the 15 indicators applicable to CCWF. Of these 12 indicators, OIG clinicians rated one ***proficient***, nine ***adequate***, and two ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 26 detailed case reviews they conducted. Of these 26 cases, 23 were adequate and three were inadequate. In the 1,617 events reviewed, there were 388 deficiencies, 77 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 CCWF:

- Medical leadership was well respected by staff. Despite COVID-19 restrictions, leadership, providers, and nursing staff were dedicated to patient care. Providers and nurses continued to see patients and utilized creative solutions to provide care to the patient population, such as telemedicine evaluations through laptops.

- Nursing leadership was instrumental in ensuring staff received regular updates on the rapidly changing COVID-19 guidelines. Supervising registered nurses (SRN II's) used a hands-on approach and assumed staff duties in emergency situations, when needed.

- The institution held population management meetings which included all members of the patient care team. Patient care teams were very knowledgeable about their patients,

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

collaborated to provide care to even the most difficult patients, and documented progress notes for morning huddles.

Our clinicians found the following weakness at CCWF:

- Although the institution focused efforts on high-risk yards and kept those backlogs low, CCWF still had a problematic number of patient backlogs.
- During emergency situations, TTA nurses struggled with critical decision making, timely evaluations for patients, and delayed notification to providers of abnormal findings. Also, there were notable problems with medical reconciliation for patients returning from the hospital.
- Although most providers made clear and reasonable medical decisions, some providers made questionable decisions. We noted an improvement in provider decision-making compared with Cycle 5.

Compliance Testing Results

Our compliance inspectors assessed 12 of the 15 indicators applicable to CCWF. Of these 12 indicators, our compliance inspectors rated two ***proficient***, seven ***adequate***, and three ***inadequate***. We tested only policy compliance in the Health Care Environment, Preventative Services, and Administrative Operations indicators, as these do not have a case review component.

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

- Pregnant patients had timely provider visits, and nursing staff documented vital information. The institution offered lower-tier housing and lower-bunk accommodations and provided prenatal screening tests to pregnant patients.
- Medical staff timely scanned initial health care screening forms, community hospital discharge reports, and requests for health care services into patients' electronic medical records.
- Nursing staff reviewed health care services request forms and performed face-to-face encounters timely.
- CCWF provided timely appointments for patients returning from hospital admission and specialty services.

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

- Patients did not always receive their chronic-care medications within the required time frames. Medication continuity was poor for patients returning from hospitalizations, admitted to specialized medical housing, arriving from non-CDCR facilities, and transferring within CCWF.

- The institution performed poorly in completing the emergency medical response event checklist. Also, medical staff did not submit initial inmate death reports to CCHCS per policy requirements.

- Medication nurses did not follow universal hand hygiene precautions when administering medication.

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 for three of five diabetic measures to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered CCWF's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. CCWF's results compared favorably with those found in State health plans for diabetic care measures. We list the eleven 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)—CCWF performed better in two of the three diabetic measures that have statewide comparative data, poor HbA1c

control and blood pressure control. Kaiser NorCal and Kaiser SoCal outperformed CCWF in HbA1c screening.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include this data for informational purposes. CCWF had a 71 percent influenza immunization rate for adults 18 to 64 years old and a 73 percent influenza immunization rate for adults 65 years of age and older.[10] The pneumococcal vaccine rate was 90 percent.[11]

Cancer Screening

When compared with statewide Medi-Cal programs (California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal), CCWF performed better in one of the two cancer screening measures that have statewide comparative data: breast cancer screening. Kaiser NorCal and Kaiser SoCal outperformed CCWF in cervical cancer screening.

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. CCWF had an 82 percent colorectal cancer screening rate.

[10] The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result. The sample for older adults did not include a full sample.

[11] The pneumococcal vaccines administered are the 13 valent pneumococcal vaccine (PCV13) 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 the one in which the patient was currently housed during the inspection period.

Table 5. CCWF Results Compared with State HEDIS Scores

HEDIS Measure	CCWF Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	86%	90%	94%	**96%**
Poor HbA1c Control (> 9.0%) ‡, §	**5%**	34%	25%	18%
HbA1c Control (< 8.0%) ‡	86%	–	–	–
Blood Pressure Control (< 140/90) ‡	**89%**	65%	78%	84%
Eye Examinations	14%	–	–	–
Influenza – Adults (18–64)	71%	–	–	–
Influenza – Adults (65+)	73%	–	–	–
Pneumococcal – Adults (65+)	90%	–	–	–
Breast Cancer Screening (50–74)	**85%**	62%	82%	84%
Cervical Cancer Screening	76%	65%	**87%**	83%
Prenatal Care‖	N/A	91%	**96%**	92%
Postpartum Care‖	N/A	78%	**82%**	81%
Colorectal Cancer Screening	**82%**	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in February 2021 by reviewing medical records from a sample of CCWF'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, 2019–June 30, 2020 (published April 2021). www.dhcs.ca.gov/documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol3-F2.pdf.

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

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

‖ For this indicator CCWF had a nontestable sample size as only three patients transferred to the institution requiring prenatal services, and only one patient delivered at CCWF during the 12-month test period.

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 CCWF's performance, we offer the following recommendations to the department:

Access to Care

- CCHCS leadership should implement policies to address patient complaints within appropriate time frames in the skilled nursing facilities and other specialized medical housing units.
- Medical leadership should ensure that if hospital or specialty follow-up visits occur outside of regular clinic hours, that ordering all follow-up visits and diagnostic studies is completed upon return to the institution. This places the patient at risk of loss to follow-up.
- Medical leadership should ensure that patients with chronic care follow-up appointments, nurse-to-provider referrals, and subsequent specialty follow-up appointments are timely received.

Diagnostic Services

- Medical leadership should consider establishing a policy to ensure patients in the Custody Community Transitional Reentry Program (CCTRP) who return to the institution receive routine standardized intake laboratory testing similar to patients in the Reception Center.
- Medical and nursing leadership should ensure providers endorse stat laboratory results and nursing staff notify providers within the required time frames.

Emergency Services

- Medical and nursing leadership should consider incorporating into the Emergency Medical Response Review Committee (EMMRC) periodic reviews of medical emergencies which do not require transfer to higher level of care.
- Nursing leadership should ensure nurses notify the provider of abnormal clinical findings in a timely manner.
- Nursing leadership should provide refresher training on completing reassessments for patients with urgent symptoms in the TTA.

Health Information Management

- Medical leadership should determine the cause of untimely retrieval of specialty reports and implement remedial measures as appropriate.

- The department should consider adjusting the menu on the results letter in the electronic health records system (EHRS) to default to *patient letter* instead of Developmental Disability Program (*DDP)-Scan letter* and train providers to generate letters appropriately.

- Medical leadership should ensure providers relay pathology results to patients timely.

- The department should consider developing and implementing a template that auto populates with all elements required per CCHCS policy for patient results letters.

Health Care Environment

- Executive leadership should consider performing random spot checks to ensure medical supply storage areas located outside the clinics store medical supplies adequately.

- Nursing leadership should consider performing random spot checks to ensure clinics meet the requirements for essential core medical equipment and supplies.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure EMRBs are regularly inventoried including a daily quality control of the glucometers.

Transfers

- Nursing leadership should consider reminding nursing staff to fully document tuberculosis (TB) symptoms as part of the patient's initial health assessment.

- Medical and nursing leadership should ensure hospital discharge and intra-facility transfer medications are reconciled, ordered, and administered timely without interruption.

- Medical and nursing leadership should consider establishing a policy to require medication reconciliation prior to the next scheduled medical administration.

- The department should consider developing and implementing an electronic alert to ensure nurses in the receiving and release

clinic (R&R) properly complete initial screening questions and follow up as needed.

Medication Management

- Medical and nursing leadership should identify the causes of the challenges to medication continuity for chronic care, hospital discharge, and specialized medical housing patients and implement remedial measures as appropriate.

- Medical and nursing leadership should ensure hospital discharge, reception center transfers, intra-facility transfers, chronic care, and newly ordered medications are timely ordered, made available, and administered to the patients without interruptions.

- Nursing leadership should consider reminding nursing staff to document patient refusals in medical administration records, as described in the CCHCS policy and procedures.

Preventive Services

- Nursing leadership and the public health nurse should educate nursing staff to fully document TB symptoms as part of the patient's TB medication monitoring.

- Nursing leadership and the public health nurse should educate nursing staff in timely and accurate monitoring of patient's annual TB screening per CCHCS policy.

Nursing Performance

- Nursing leadership should consider refresher training for providers on the requirement that all transitional care unit admissions have a detailed plan of care with measurable objectives.

- Nursing leadership shoulder remind certified nursing assistants to report abnormal vital signs to a registered nurse or provider.

Provider Performance

- Medical leadership should consider specific training on improved documentation and monitored medical decision making for providers who have the most deficiencies in our case reviews.

Reception Center

- The department should consider developing and implementing an electronic alert to ensure nurses in the R&R clinic complete initial health screening questions and follow up with patients as needed.

Specialized Medical Housing

- Nursing leadership should ensure nurses in the skilled nursing facility (SNF) thoroughly assess patients and document the assessments along with wound care.

- Nursing leadership should ensure nurses initiate care plans and reassess patients at regular intervals.

Specialty Services

- Medical leadership should ensure providers follow specialty recommendations and, if not, that providers document medical reasoning.

- Medical leadership should ensure patients receive their ordered follow-up specialty appointment services timely.

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
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(80.5%)

Results Overview

Compared with Cycle 5, CCWF improved overall and provided good access to care. Compliance testing found the institution's nursing performed exceptionally well in responding timely to requests for services. Providers performed well in following up with patients after hospital discharge and specialty service appointments, but performed poorly in seeing nursing referrals and intra-facility transfer patients within required time frames. Also, chronic care appointments did not occur timely; however, this was mitigated by provider chart reviews in lieu of face-to-face visits. After reviewing all aspects of access to care, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 280 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified 18 deficiencies relating to access to care, eight of which were significant.[12]

Access to Clinic Providers

Compliance testing found chronic care face-to-face follow-up appointments occurred 52.0 percent of the time; however, this was mitigated by chart reviews performed in lieu of face-to face visits (MIT 1.001). Although the compliance score was low, we interpret overall care as being acceptable because those patients who needed to be seen, in fact, were evaluated by the provider. Due to movement restrictions related to the COVID-19 pandemic, we considered most cases of provider chart reviews as triage of nonurgent, low- or medium-risk chronic care appointments as an acceptable alternative to face-to-face or telephonic visits.

[12] Deficiencies were found in cases 1, 2, 6, 8, 10, 17, 18, 34, 38, 44, 46, 49, 51, 52, and 54. Significant deficiencies occurred in cases 2, 10, 17, 44, and 52.

Compliance testing also found providers saw patients referred by a nurse 55.6 percent of the time (MIT 1.005). Out of 30 samples, nine required a provider follow-up appointment, and only five of the nine were completed timely.

Providers saw patients referred by their primary care provider for follow-up sick call appointments 100 percent of the time; however, the sample size was only two (MIT 1.006). OIG clinicians reviewed 127 outpatient provider encounters and found provider visits usually occurred within required time frames; however, eight deficiencies were identified, two of which were significant:[13]

- In case 2, the patient was scheduled at the same time for a dialysis appointment and a provider appointment, so the patient was not able to see the provider.
- In case 44, the patient reported not having a menstrual cycle and was scheduled for a provider appointment; however, the provider saw her 36 days late.

Access to Specialized Medical Housing Providers

CCWF performed poorly on completing admission history and physicals. Compliance testing revealed only 70.0 percent of patients in the SNF had admission history and physicals performed timely (MIT 13.002).

Access to Clinic Nurses

CCWF provided adequate access to clinic nurses. Compliance testing found that same day triage appointments and RN clinic appointments were timely (MIT 1.003, 76.7% and MIT 1.004, 86.7%). Our case reviews found similar results; only three deficiencies were noted, one of which was significant.[14]

Access to Specialty Services

CCWF performed well in obtaining initial specialty care for their patients; however, the institution could improve in providing high-priority specialty follow-up appointments. Compliance testing found patients saw specialists within required time frames for high-priority referrals 100 percent of the time, medium-priority referrals 86.7 percent of the time, and routine-priority referrals 80.0 percent of the time

[13] Deficiencies occurred in cases 2, 8, 18, 44, 46, 49, 51 and 54. Significant deficiencies occurred in cases 2 and 44.

[14] Deficiencies occurred in cases 46 and 49. The significant deficiency occurred in case 2.

(MIT 14.001, MIT14.004, and MIT 14.007).OIG clinicians noted similar findings, identifying only one minor deficiency in case 38.

The institution ensured follow-up specialty appointments for medium-priority specialty visits occurred timely (MIT 14.006, 100%); however, medium-priority and high-priority follow-up specialty appointments had room for improvement (MIT 14.009, 71.4% and MIT 14.003, 50.0%). OIG case reviewers found three deficiencies related to delayed specialty follow-up appointments and all were considered significant:

- In case 17, the patient had a broken hearing aid; however, the patient's follow-up audiology appointment occurred 176 days late.
- Also in case 17, the patient required an ophthalmology follow- up appointment for glaucoma, a condition that can threaten vision. The specialist recommended the patient receive a glaucoma follow-up appointment in one to two months; however, the appointment only occurred over a year after the referral.
- In case 34, the provider ordered a cardiology follow-up appointment for a patient in August 2020. At the time of our onsite inspection, the appointment had not occurred.

Follow-Up After Specialty Service

CCHCS specialty follow-up policy has changed since our Cycle 5 inspection and now states that providers are only required to perform face-to face appointments for patients with urgent priority referrals. Providers may see patients after specialty medium- and routine-priority appointments at the provider's discretion. As in Cycle 5, CCWF providers generally saw patients after specialty visits within ordered time frames (MIT, 1.008, 90.5%). This is consistent with the OIG clinician findings.

Follow-Up After Hospitalization

The institution generally ensured providers followed up with patients returning from an outside hospital. Compliance testing found most discharged patients had a punctual follow-up appointment with their providers (MIT 1.007, 94.1%). Our case review findings were consistent with the compliance review; however, our clinicians noted a pattern of poor quality provider follow up when appointments occurred. These deficiencies occurred in case 10, with one provider:

- In case 10, a high-risk patient returned from a hospital visit for chest pain and elevated blood pressure with a

recommendation for further outpatient testing with a heart specialist. The provider saw the patient upon return from the hospital and deferred the specialty referral to the patient's next appointment. However, the appointment did not occur and the orders were not placed.

Follow-Up After Urgent or Emergent Care (TTA)

Our clinicians found provider follow up usually occurred after urgent or emergent care and identified only one deficiency which was significant:

- In case 52, the TTA provider ordered 24-hour follow up for the patient after a visit for an ear procedure. The follow up did not occur for 12 days.

Follow-Up After Transferring into the Institution

Providers performed well in completing history and physicals within seven days of arrival (MIT 12.004, 100%), however, performed poorly in patient follow up after the patient transferred into the institution. The compliance score for the initial health screening by a clinician was 69.2 percent (MIT 1.002). OIG clinicians found no deficiencies in provider appointment access for patients transferring into the institution.

Clinician On-Site Inspection

The OIG clinicians met with medical leadership, scheduling management, and staff during our on-site inspection. We found that specialty services and scheduling were fully staffed during the review period. Due to the COVID-19 pandemic, providers worked both remotely and on-site during our review period and were available for appointments. For 7,362 nursing referrals for providers, the backlog was 854 referrals and was between three to 172 days late, primarily for low-risk yards. The RN clinic visit backlog was 81 patients, also with most on low-risk yards. Specialty services had a backlog of 461 visits, primarily from optometry, physical therapy, ophthalmology, and general surgery. The facility advised these were difficult to obtain services for during the COVID-19 pandemic.

Medical leadership said they spoke with the CCHCS headquarters management regarding the ambiguity in the COVID-19 policy on how to close, in the EHRS, outpatient provider appointments that were not seen. They were advised to mark as cancelled, not completed, visits that were not seen face-to-face or had a phone consultation. This is an accurate representation of what patient care occurred.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	13	12	0	52.0%
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) *	9	4	0	69.2%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	23	7	0	76.7%
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) *	26	4	0	86.7%
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) *	5	4	21	55.6%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	2	0	28	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	16	1	0	94.1%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	38	4	3	90.5%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
Overall percentage (MIT 1): **80.5%**				

* 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) *	1	0	19	100%
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) *	20	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) *	7	3	0	70.0%
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) *	N/A	N/A	N/A	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) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	4	4	7	50.0%
Did the patient receive the medium-priority specialty service within 15–45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	0	9	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	5	2	8	71.4%

* 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.

Recommendations

- CCHCS leadership should implement policies to address patient complaints within appropriate time frames in the skilled nursing facilities and other specialized medical housing units.

- Medical leadership should ensure that if hospital or specialty follow-up visits occur outside of regular clinic hours, that ordering all follow-up visits and diagnostic studies is completed upon return to the institution. This places the patient at risk of loss to follow-up.

- Medical leadership should ensure that patients with chronic care follow-up appointments, nurse-to-provider referrals, and subsequent specialty follow-up appointments are timely received.

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 immediate (stat) laboratory tests.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(75.8%)

Results Overview

As in Cycle 5, CCWF had excellent performance in completing and retrieving diagnostic tests and usually retrieved and endorsed laboratory, radiology, and pathology results timely. However, pathology reports were often not relayed to the patients. Overall, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 381 diagnostic events and found 72 deficiencies, of which only four were significant.[15] Sixty deficiencies were related to health information management, 10 were related to provider care, one pertained to nursing, and one pertained to the completion of diagnostic tests.

For health information management, we considered test reports that were never retrieved or reviewed as severe a problem as tests that were not performed.

Test Completion

CCWF performed well in timely radiology and laboratory test completion (MIT 2.001, 100% and MIT 2.004, 80.0%). Compliance testing found 80.0 percent of stat laboratory tests were collected as ordered (MIT 2.007). The OIG clinicians found no issues with stat labs and identified only one minor deficiency in test completion.

Although routine testing is usually required for new patients in the reception center, our clinicians noted that returning patients in the Custody Community Transitional Reentry Program (CCTRP) do not receive routine intake laboratory tests that are normally ordered for reception center patients.

[15] Deficiencies occurred in cases 1, 3- 15, 17, 32, 33, 34, 36-38, and 39. Significant deficiencies occurred in cases 1, 14, and 36.

Health Information Management

Compliance testing found radiology and laboratory reports were usually received and endorsed timely (MIT 2.002, 100% and MIT 2.005, 90.0%). Pathology reports were received and endorsed timely 80.0 percent of the time (MIT 2.011), but pathology results were often not relayed to the patients (MIT 2.012, 40.0%). Compliance testing found STAT labs were always endorsed by the provider timely (MIT 2.009, 100%). Our case reviewers found no deficiencies in STAT or pathology reports.

The OIG case reviewers found 60 deficiencies in diagnostic services related to health information management. Most were minor deficiencies related to missing test dates and whether patient results letters showed normal results. Thirteen of the deficiencies were due to mislabeled, misfiled, or duplicate medical documents and not retrieving or endorsing medical documents.[16] Only three deficiencies were significant:

- In case 14, a urine culture result was not retrieved or scanned into the patient's electronic medical record.
- In case 38, a provider endorsed an imaging study to evaluate for metastatic cancer almost three months late.
- In case 36, the patient had an important body scanning study performed; however, the result was not scanned into the patient's electronic medical record.

We also noted a pattern of providers not endorsing urine dip results.[17]

Clinician On-Site Inspection

Our case review team met with laboratory and radiology supervisors and staff during the on-site inspection. The facility performed most laboratory and radiology tests timely, despite the significant increase in workload from the COVID-19 pandemic.

According to CCWF medical leadership, CCHCS policy does not consider CCTRP patients new intakes, even though these patients can spend an extended amount of time in the community, are at risk of contracting diseases such as HIV, Hepatitis C, gonorrhea, and chlamydia, and can transmit these diseases to other inmates. Medical leadership advised they would consider applying new intake testing to these inmates if they return from the community.

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[16] Deficiencies were noted in cases 3, 7, 9, 11, 33, 36, 38, and 39.

[17] Urine dip results were not endorsed in cases 3, 10, and 14.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	6	4	0	60.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	3	7	0	30.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	8	2	0	80.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008) *	6	4	0	60.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	10	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	9	1	0	90.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	4	6	0	40.0%
Overall percentage (MIT 2): **75.8%**				

* 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.

Recommendations

- Medical leadership should consider establishing a policy to ensure patients in the Custody Community Transitional Reentry Program (CCTRP) who return to the institution receive routine standardized intake laboratory testing similar to patients in the Reception Center.

- Medical and nursing leadership should ensure providers endorse stat laboratory results and nursing staff notify providers within the required time frames.

Emergency Services

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Results Overview

CCWF performed poorly in emergency care. Similar to Cycle 5, CCWF nurses continued to perform incomplete nursing reassessments, frequently failed to elevate symptomatic patients with significantly abnormal vital signs to providers, and delayed interventions ordered by providers. However, providers generally made appropriate clinical decisions. The institution showed significant improvement in documenting the first medical responder form and identifying training deficiencies in EMRRC. Overall, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 76 urgent and emergent events and identified 52 emergency care deficiencies, 17 of which were significant.[18]

Emergency Medical Response

CCWF staff responded promptly to emergencies throughout the institution. They initiated cardiopulmonary resuscitation (CPR), activated emergency medical services (EMS), and notified TTA staff in a timely manner.

Provider Performance

CCWF providers performed adequately in urgent and emergent situations, and after-hours care. In most cases, the providers were available to respond to emergencies, demonstrated good medical judgement, and documented appropriately.

[18] Significant deficiencies occurred in cases 1, 2, 9, 10, 33, and 34.

Of the 49 deficiencies identified in emergency care, seven were related to provider performance, of which three were significant. Two of the three significant deficiencies are discussed below:[19]

- In case 10, the patient with high cardiac risk was sent to the TTA for chest pain and extremely elevated blood pressure. The provider delayed sending the patient to a higher level of care for nearly 45 minutes.

- Also in case 10, the patient again presented to the TTA with extremely elevated blood pressure, chest pain, and nausea with vomiting. The provider waited four hours to order blood pressure treatment, did not order an electrocardiogram (EKG) to evaluate whether symptoms were heart related, and did not write an on-call note to justify medical reasoning.

Nursing Performance

CCWF nurses had prompt responses, but did not perform well in emergency events. Similar to Cycle 5, TTA nurses continued to have incomplete nursing assessments and failed to notify providers when patients warranted further evaluation and treatment. In addition, the TTA nurses did not transport some patients with acute and urgent symptoms to TTA for continued observation and treatment. The nurses' failure to observe patients in TTA led to a delay in medically necessary treatment for high-risk patients with acute conditions.

The following cases illustrate nurses responding timely to patient symptoms, yet not performing appropriate interventions.

- In case 1, the high-risk patient with multiple chronic conditions complained of abdominal pain. The patient was seen two days earlier for nausea, vomiting, and jaundice.[20] The TTA nurse responded to the housing unit and advised the patient to submit a sick call request for additional symptoms, but did not intervene appropriately by transporting the patient to the TTA for further assessment. Subsequently, the patient sought urgent medical care for similar symptoms, and was transported to higher level of care at a community hospital where she was diagnosed with pancreatic cancer.

- In case 34, the patient complained of chest pain and had cardiac risk factors of hypertension, hyperlipidemia, and oral

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[19] Two minor deficiencies occurred in separate events on case 34 and once in case 1. Two significant deficiencies were identified in case 10.

[20] Jaundice is yellowish discoloration of the skin, which is a sign indicating possible liver disease.

contraceptives. The patient was released to housing instead of being transported to the TTA to perform an EKG and notify the provider.

In the following cases, CCWF nurses performed incomplete assessments for patients evaluated for urgent symptoms:

- In case 1, the patient was under observation in TTA for abdominal pain with nausea and vomiting. The TTA nurses received orders to transport the patient to higher level of care via state car. However, the nurses did not reassess the patient for four hours pending transport to a higher level of care or provide hand-off communication to the receiving facility.

- In case 10, the patient received emergency care for abdominal pain, nausea, and vomiting. Nurses observed the patient in the Transitional Care Unit (TCU) without contacting the provider, resulting in a 45-minute delay transporting the patient to TTA. Later, the patient was transferred to a higher level of care.

- Later on in case 10, the patient received emergency care for severe chest pain, nausea, and vomiting. During observation, the patient's blood pressure remained abnormally elevated after pain medication was administered. The TTA nurse did not reassess the effectiveness of the pain medication or notify the provider 2 ½ hours later of abnormal vital signs. For five hours, the TTA nurse also failed to reassess the patient's respiratory rate, pulse, temperature, and oxygen saturation, important parameters to assess the medical stability of a patient's respiratory status.

- In case 33, the patient received urgent care for chest pain and was monitored in the TTA for two and a half hours. The TTA nurse did not reassess the patient after the initial assessment or prior to discharge. Furthermore, the nurse did not notify the provider of the patient's condition.

- In case 34, a medical emergency was called for the patient who had symptoms of chest pain and facial and eye swelling. The TTA nurse did not assess the patient's face for complaints of swelling.

Nursing Documentation

As in Cycle 5, CCWF continued to struggle with nursing documentation. Although nursing staff improved significantly in documenting the first medical responder form, during our review we found the following:

- In case 1, the patient was sent to higher level of care to evaluate for symptoms of abdominal pain. The TTA nurse did not document the patient's condition or an assessment prior to transfer.
- In case 2, the TTA nurse did not document the patient's respiratory assessment after the TTA nurse administered breathing treatments to the patient.
- In case 33, the patient was observed in TTA for chest pain. The TTA nurse did not document a cardiac reassessment for two and a half hours.

Emergency Medical Response Review Committee

Our inspectors reviewed ten EMRRC events in eight cases. CCWF staff regularly conducted clinical reviews of nonscheduled emergency transports each business day. The chief medical executive (CME) and chief nursing executive (CNE) or designee reviewed each event and determined whether each case should be assigned to EMRRC for further review. The institution maintained a log of all EMRRC events along with the disposition of the final actions of the review. In addition, EMRRC reviewed all emergency responses and identified most opportunities for improvement.

Clinician On-Site Inspection

The TTA is staffed 24-hours a day with two RNs on each shift, a certified nursing assistant on second watch, and a provider on daily assignment. During the Covid-19 pandemic, the TTA provider performed face-to-face visits for patients requiring assessments from clinic provider appointments which occurred via telework. The medical officer of the day was assigned to take calls after 4pm, and the TTA rover (an RN) responded to all medical emergencies throughout the institution. In addition to medical emergencies, TTA staff process all patients returning from the hospital and specialty appointments and triage weekend sick call requests for emergent and urgent symptoms.

Prior to our on-site visit, the CCWF nursing leadership team had identified lapses in documentation for nursing assessments and protocols and implemented a monitoring plan to evaluate the progression of nursing documentation.

Recommendations

- Medical and nursing leadership should consider incorporating into the Emergency Medical Response Review Committee (EMMRC) periodic reviews of medical emergencies which do not require transfer to higher level of care.
- Nursing leadership should ensure nurses notify the provider of abnormal clinical findings in a timely manner.
- Nursing leadership should provide refresher training on completing reassessments for patients with urgent symptoms in the TTA.

Health Information Management

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
***Proficient* (89.3%)**

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.

Results Overview

As in Cycle 5, CCWF performed well scanning health care service request forms, hospital discharge records, diagnostic results, and specialty reports. Most hospital discharge records contained all medically required components. However, specialty report retrievals were often delayed. Also, providers did not always complete patient result letters according to CCHCS policy and did not always send pathology result letters to patients. The OIG rated this indicator ***adequate***.

Case Review and Compliance Results

The clinicians reviewed 1,616 events and found 82 deficiencies related to health information management, six of which were significant.[21]

Hospital Discharge Reports

Compliance testing revealed that all hospital records were received, scanned into the medical record and reviewed properly (MIT 4.003, 100% and MIT 4.005, 100%). OIG clinicians reviewed 18 hospital visits and identified two deficiencies in health information management, only one of which was significant:

- In case 34, the records from the patient's visit to the emergency room were not retrieved or scanned into the patient's electronic medical record.

Specialty Reports

Similar to Cycle 5, CCWF had adequate performance with specialty reports. Compliance testing found specialty documents were generally

[21] Deficiencies occurred in cases 1-5, 7-15, 17, 32-34, 36-38, and 39. Significant deficiencies occurred in cases 14, 33, 34, 36, and 38.

scanned timely (MIT 4.002, 80.0%). High-priority specialty consultation reports were received and reviewed timely (MIT 14.002, 80.0%); however, retrieval and review of medium- and routine-priority specialty consultation reports needed improvement (MIT 14.005, 46.7% and MIT 14.008, 71.4%).

Of the 84 specialty consultations our clinicians reviewed, 13 deficiencies were identified related health information management, only one of which was significant. Deficiencies included late or missing provider endorsements, delayed receipt of specialty consultation reports, and misfiled reports. One specialty consultation note was sent to the wrong provider, resulting in delayed cancer care follow up.[22] We discuss these finding in more detail in the **Specialty Services** indicator.

Diagnostic Reports

CCWF performed poorly with diagnostic reports. The providers reviewed and endorsed diagnostic tests timely, but often did not communicate the results to the patient. Compliance testing found providers frequently reviewed and endorsed pathology results; however, they usually did not relay the results to the patient (MIT 2.011, 80.0% and MIT 2.012, 40.0%). Nurses advised providers of stat laboratory results and the providers acknowledged the results only 60.0 percent of the time (MIT 2.008).

The OIG clinicians reviewed 387 diagnostic events. Of these 387 diagnostic events, the clinicians identified 60 deficiencies related to health information management, three of which were significant.[23] Most deficiencies were due to patient result letters missing all required components. Case reviewers found a pattern of urine dip results not being endorsed. However, we found two pathology reports which were reviewed and discussed with the patient timely. We discuss the deficiencies further in the **Diagnostic Services** indicator.

Urgent and Emergent Records

OIG clinicians reviewed 64 emergency care events and found CCWF nurses recorded these events sufficiently. Providers usually recorded their emergency care sufficiently, but deficiencies in documentation did occur. Additional information regarding emergency care documentation can be found in the **Emergency Services** indicator.

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[22] Minor deficiencies were noted in cases 1-3, 7, 9, 17, 33, and 36. One significant deficiency was noted in case 38.

[23] Minor diagnostic HIM deficiencies were noted in cases 1, 3-5, 7-15, 17, 32-34, 36-38, and 39. Significant deficiencies were found in cases 14, 36, and 38.

Scanning Performance

CCWF performed poorly with scanning and labeling documents. Three of five patient letters reviewed were mislabeled as DDP document types rather than patient letters. Two specialty documents were not scanned (MIT 4.004, 66.7%). The OIG clinicians also identified late retrieval and endorsement of specialty documents. These findings are discussed further in the **Specialty Services** indicator. The OIG clinicians found most hospital and emergency room notes and laboratories were endorsed timely.

Our clinicians identified 13 deficiencies related to mislabeled, misfiled, and duplicate medical documents, and medical documents that were not scanned.[24] Four of the deficiencies were significant:

- In case 14, a urine culture was not scanned into the patient's electronic medical record.
- In case 33, an EKG was performed but not scanned into the patient's electronic medical record.
- In case 34, the report from the patient's emergency room visit was not retrieved.
- In case 36, the patient's body imaging scan was not scanned into their electronic medical record.

Clinician On-Site Inspection

We discussed health information management processes with CCWF nurses, providers, office technicians, health information management supervisors, and ancillary and diagnostic staff. During the COVID-19 pandemic, the institution was well staffed and maintained social distancing guidelines by alternating days off for staff as telework was not available for health information management staff.

Health information management staff explained that the radiology staff was responsible for scanning radiology results into the medical record, the laboratory staff ensured laboratory results were imported into the medical record, and health information management staff monitored endorsements of documents by providers. The OIG clinicians learned that in 2020, health information management staff started sending reports to providers detailing missing endorsements and beginning in 2021, they initiated an active role in following up with medical management to ensure endorsements were completed.

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[24] Minor deficiencies were noted in cases 3, 7, 9, 11, 33, 36, and 39.

Many problems identified in this indicator were due to incomplete patient results notifications. Providers reported they were either not aware of the requirement to include the identifying date in the letter or they used the default template provided in the electronic health record system (EHRS), which does not include all letter components. Health information management reported that medical leadership is responsible for training providers on the appropriate components of patient results letters. Health information management also advised they are not responsible for ensuring provider documents are complete, include all necessary medical components, or do not contain cloned elements.

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	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	24	6	15	80.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	15	0	2	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	16	8	0	66.7%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	17	0	0	100%
Overall percentage (MIT 4): **89.3%**				

* 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) *	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	6	4	0	60.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	9	1	0	90.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	4	6	0	40.0%
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) *	12	3	0	80.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	7	8	0	46.7%
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) *	10	4	1	71.4%

* 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.

Recommendations

- Medical leadership should determine the cause of untimely retrieval of specialty reports and implement remedial measures as appropriate.

- The department should consider adjusting the menu on the results letter in the electronic health records system (EHRS) to default to *patient letter* instead of Developmental Disability Program (*DDP)-Scan letter* and train providers to generate letters appropriately.

- Medical leadership should ensure providers relay pathology results to patients timely.

- The department should consider developing and implementing a template that auto populates with all elements required per CCHCS policy for patient results letters.

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.

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(79.6%)

Results Overview

CCWF's performance improved in health care environment when compared with the Cycle 5 inspection. The institution improved in adherence to universal hand hygiene precautions and medical supply management protocols. In addition, with some of the Health Care Facility Improvement Program projects completed, CCWF's common clinic areas and clinic exam rooms were conducive in providing medical services. However, various aspects of the institution's health care environment still needed improvement: multiple clinics were missing essential medical equipment; daily performance checks on automated external defibrillator (AED) were either not properly logged or not recorded at all; and inventories were not performed for emergency medical response bags (EMRBs). We rated this indicator ***adequate***.

Outdoor Waiting Areas

We examined CCWF's outdoor patient waiting areas (see Photo 1, next page). Health care and custody staff reported the existing waiting areas had sufficient seating capacity. The clinic provided additional folding chairs to practice social distancing (see Photo 2, next page). According to staff, they only call patients close to their appointment time during inclement weather.

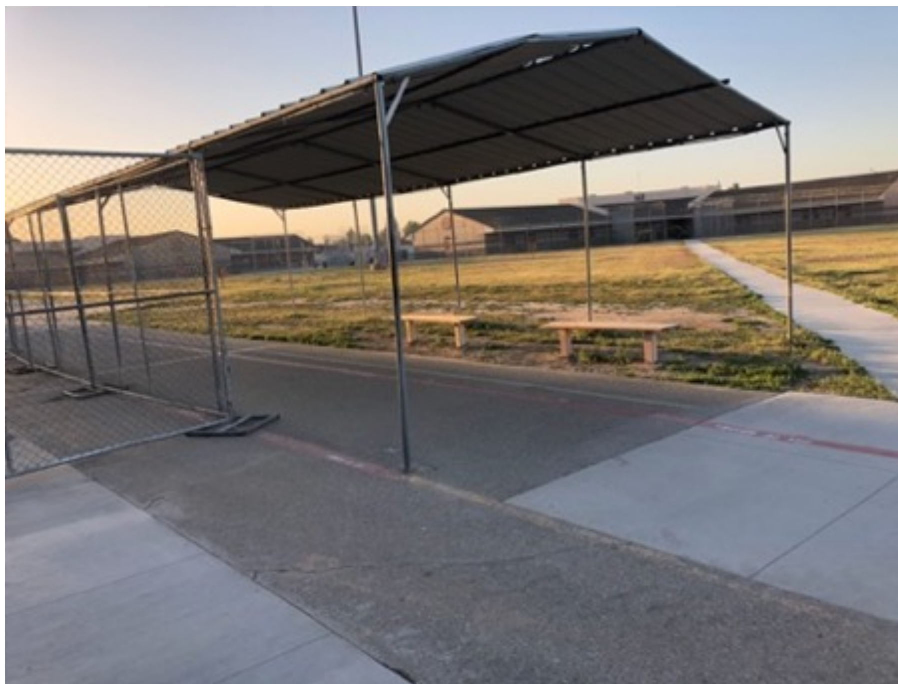

Photo 1. A clinic outdoor waiting area (photographed April 16, 2021).

Photo 2. A clinic's extra folding chairs used to practice social distancing (photographed April 16, 2021).

Indoor Waiting Areas

We inspected CCWF's indoor waiting areas. Health care and custody staff reported the existing indoor waiting areas had sufficient seating

capacity that provided patients protection from inclement weather (see Photo 3, below). Custody staff reported they bring in a few patients at a time to prevent overcrowding the indoor waiting areas and to maintain safe social distancing during the pandemic. During our inspection, we did not observe overcrowding in the clinics' waiting areas.

Photo 3. D clinic indoor waiting area (photographed April 15, 2021).

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 (MIT 5.109, 100%).

All applicable clinics contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 100%).

Clinic Supplies

Eight of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 80.0%). In two clinics, we found unidentified medical supplies.

Six of the 10 clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, 60.0%). We found one or more of the following deficiencies in four clinics: missing nebulization unit, and staff either did not properly log the results of the automated external defibrillator (AED) checklist or the clinic did not have an AED log for staff to record test results within the last 30 days.

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked if staff inspected the bags daily and inventoried them monthly. Only five of the nine EMRBs passed our test (MIT 5.111, 55.6%). In one clinic, staff failed to ensure daily glucometer quality control was completed. In the remaining three clinics, staff had not inventoried EMRBs when the seal tags were replaced.

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 medications stored temporarily in the medical warehouse (see Photo 4, next page).

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 communication process with the existing system.

Photo 4. Expired glucose gel, dated February 2021and March 2021 (photographed April 12, 2021).

Infection Control and Sanitation

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

Staff in all applicable clinics properly sterilized or disinfected medical equipment (MIT 5.102, 100%).

We found operating sinks and hand hygiene supplies in examination rooms in all applicable clinics (MIT 5.103, 100%).

We observed patient encounters in five clinics. In one of the five clinics, although the provider rinsed his hands before and after patient encounters, he did not use an antiseptic soap or alcohol-based sanitizer (MIT 5.104, 80.0%).

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

Physical Infrastructure

The institution's health care management and plant operations manager reported that all clinical area infrastructures were in good working order. At the time of our medical inspection, CCWF's administrative team reported fourteen Health Care Facility Improvement Program (HCFIP) construction projects. Some projects were pending completion of other projects, while others had already broken ground or were nearing project completion. All fourteen projects were renovation of clinic spaces designed to provide improvements in the quality of patient care. The institution reported that completion of the majority of the projects would be delayed due to the COVID-19 pandemic (MIT 5.999).

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	10	0	0	100%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	10	0	0	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	10	0	0	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	4	1	5	80.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	8	2	0	80.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	6	4	0	60.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	9	0	1	100%
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)	5	4	1	55.6%
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): **79.6%**			

* 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

Recommendations

- Executive leadership should consider performing random spot checks to ensure medical supply storage areas located outside the clinics store medical supplies adequately.

- Nursing leadership should consider performing random spot checks to ensure clinics meet the requirements for essential core medical equipment and supplies.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure EMRBs are regularly inventoried including a daily quality control of the glucometers.

Transfers

Overall Rating
Adequate

Case Review
Adequate

Compliance Score
Inadequate
(61.1%)

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution, as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health 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

CCWF had a mixed performance in this indicator. Our clinicians found nursing assessments and interventions improved at CCWF compared with Cycle 5. The institution significantly improved in assessing patients transferring out of the institution with complete vital signs. When patients arrived at CCWF, nurses performed appropriate assessments, notified specialty of pending appointments, and communicated well with the care management teams. However, the institution still struggled with continuity of patient care and medication for patients returning from the hospital. Overall, the OIG rated this indicator ***adequate.***

Case Review and Compliance Testing Results

OIG clinicians reviewed 22 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 14 deficiencies, two of which were significant.[25]

Transfers In

CCWF had a mixed performance in the transfer-in process. Compliance testing showed R&R nurses made incomplete initial assessments

[25] Deficiencies occurred in cases 2, 8, 10, 14 23, ,30, 32, 33, and 36. Significant deficiencies occurred in cases 33 and 36.

(MIT 6.001, zero). The nurses did not address the signs and symptoms of fatigue when screening for tuberculosis (TB). However, case review clinicians found newly arrived patients were screened within the required time frames and received appropriate assessments. Our clinicians identified minor opportunities for improvement. In one case the nurse did not take the blood sugar of a diabetic patient on dialysis and in another case, nursing staff did not complete COVID-19 quarantine rounding for three of the 14 days within the quarantine period.

In compliance testing, CCWF scored low in managing patients transferring into the institution with preapproved specialty appointments (MIT 14.010, 50.0%). There were only two samples in this compliance test. However, our case review clinicians did not find any deficiencies for transfer-in patients with specialty appointments.

Transfers Out

CCWF's transfer-out process was adequate. Although our compliance team was not able to observe CCWF's transfer-out process because no patients transferred out on the day of the OIG compliance on-site inspection, our case reviewers found that patients generally had assessments prior to transfer, notification of pending specialty appointments was completed, and patients transferred with their medication and durable medical equipment. Our clinicians reviewed seven transfer-out events. We found one minor deficiency in which the patient did not receive her newly prescribed vitamin D as ordered due to the patient transferred out two days after the medication was ordered. However, the patient received the medication at the receiving facility.

This is a significant improvement compared with Cycle 5 during which nurses frequently did not assess patients prior to transfer. In this new cycle, our clinicians did not find any deficiencies in our case review.

Hospitalizations

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

Our clinicians reviewed 20 hospital or emergency room returns in nine cases.[26] We identified 11 deficiencies, two of which were significant.[27] We found that TTA nurses generally assessed patients appropriately when they returned from the hospital or emergency room, reviewed and informed providers of hospital recommendations, and notified providers when patients returned to the facility. Providers appropriately ordered recommended specialty referrals. However, staff did not always properly reconcile mediations when the patient returned to the institution.

All hospital discharge documentations were scanned into the patient's electronic health record within three calendar days of discharge (MIT 4.003, 100%). Compliance testing also found providers routinely reviewed and endorsed documents in a timely manner (MIT 4.005, 100%).

In contrast, compliance testing showed CCWF had room for improvement in medication continuity. Ordered medications were administered, made available, or delivered to patients within the required timeframes only 28.6 percent of the time (MIT 7.003). Both clinical case reviews and compliance testing found lapses in the continuity of essential medications. Our case reviewers identified five deficiencies, one of which was significant.[28] Two deficiencies are described below.

- In case 10, the patient returned from the hospital and medication continuity did not occur for the patient's chemotherapy medication, diabetes insulin, and stomach ulcer medication.
- In case 36, the patient returned to the institution after a heart catheterization procedure. The patient's blood pressure, cholesterol, and depression medications were not appropriately reconciled with the correct dosages. In addition, our case reviewers did not find any documentation confirming that the hospital received the patient's active medication list at the time of hospital admission.

[26] Events occurred in cases 1, 2, 10, 13, 14, 15, 32,and 36.

[27] Deficiencies occurred in cases 8,10, 14, 32, 33, and 36. Significant deficiencies occurred in cases 33 and 36.

[28] Deficiencies occurred in cases 8, 10, 14, and 36. Significant deficiencies also occurred in case 36.

Clinician On-Site Inspection

During our on-site inspection, the OIG clinicians discussed the transfer-in and transfer-out processes with the R&R nurse and SRN II. We also discussed hospital returns with the TTA nursing staff.

The R&R nurse triages the transfer-in and transfer-out patients. A provider is assigned to R&R daily for order reconciliation. The nurse reported having good communication with their sister facility, California Institution for Women (CIW), which helps to ensure continuity of care for medication management. Our clinicians confirmed this on their case reviews.

According the nursing staff, there is a nursing shortage; however, the SRN II assists the nurses with intake screening and transfer-out patients when staffing is low.

For information on the on-site inspection for reception center arrivals, please see the **Reception Center** indicator.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answers			
	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	13	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)	13	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) *	10	2	1	83.3%
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): 61.1%				

* 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

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	9	4	0	69.2%
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) *	16	1	0	94.1%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	15	0	2	100%
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) *	17	0	0	100%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	4	10	3	28.6%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	16	9	0	64.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	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) *	1	1	0	50.0%

* 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.

Recommendations

- Nursing leadership should consider reminding nursing staff to fully document (tuberculosis) TB symptoms as part of the patient's initial health assessment.
- Medical and nursing leadership should ensure that hospital discharge and intra-facility transfer medications are reconciled, ordered, and administered timely without interruption.
- Medical and nursing leadership should consider establishing a policy to require medication reconciliation prior to the next scheduled medical administration.
- 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.

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.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(67.8%)

Results Overview

CCWF performed poorly in this indicator. Compliance testing showed that when compared with Cycle 5, CCWF had significantly more deficiencies in chronic care medication, new medication, and hospital medication continuity. We found a pattern of patients not receiving their 30-day supply of keep-on-person (KOP) chronic care medications within the required time frames. However, in this cycle, CCWF improved continuity of transfer medication for new arrivals. When considering the case review and compliance results together, we rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 169 events related to medication management and found 32 medication deficiencies, six of which were significant.[29]

New Medication Prescriptions

CCWF had 194 new medication prescriptions. Compliance testing showed most newly prescribed medications were not available and not administered or delivered within the required time frames (MIT 7.002, 68.0%). Our clinicians also found newly prescribed medications that were not administered timely:

- In case 7, the patient's asthma inhaler was received five days late.
- In case 16, the patient received an antibiotic medication (Amoxicillin) to treat a dental infection one day late.

[29] Deficiencies occurred in cases 1, 2, 3, 5, 6, 7,10,15, 17, 20, 30, 34, 36, 39, 47, and 51. Significant deficiencies occurred in cases 3, 5, 15, 16, 34, and 36.

- In case 51, the patient did not receive a newly prescribed rescue medication for acute asthma attacks (Xopenex) for a month.

Chronic Medication Continuity

Compliance testing found most patients did not receive their chronic care medications within the required time frames (MIT 7.001, 11.1%). Analysis of the compliance data showed KOP medications were not made available one business day prior to exhaustion or refused by patients, but when medication was refused, the reason for the refusal was not documented. In contrast, our clinicians found most patients received their chronic care medications within the required time frames; however, there were four significant deficiencies:[30]

- In case 5, the patient received the chronic care diabetic medication five days late.
- In case 16, the patient received the chronic care hypertension medication three days late.
- In case 34, the patient received the chronic care hypertension medication four days late.
- In case 36, the patient received chronic care hypertension medication four days late.

Hospital Discharge Medications

Compliance testing showed most patients returning from an off-site hospital or emergency room did not receive their medications within the required time frames (MIT 7.003, 28.6%). However, our case reviewers found most patients received their medications in a timely manner. One case had two deficiencies on separate hospital returns:

- In case 10, the patient returned from a hospital admission and missed two doses of an essential medication for diabetes (regular insulin) and received chemotherapy medication for breast cancer one day late.
- Also in case 10, the patient missed one dose of blood pressure medication prescribed for uncontrolled blood pressure after returning from the hospital. Also, the patient's cholesterol-lowering medication was administered in the morning instead of the prescribed time at bedtime.

[30] Significant deficiencies occurred in cases 3, 5, 15, 16, 34, and 36.

Specialized Medical Housing Medications

Our clinicians found the majority of the skilled nursing facility (SNF) nurses administered medications to patients within required time frames. In contrast, compliance testing found medications were not made available or administered within the required time frames in most cases (MIT 13.004, 40.0%). One patient did not receive one dose of insulin ordered for diabetes three times a day. Some patients did not receive their essential KOP medications, rescue inhalers for shortness of breath and nitroglycerin for chest pain, by the physician's ordered medication administration date.

Transfer Medications

In compliance testing, CCWF performed well in continuity of medications for patients transferring into the institution (MIT 6.003, 83.3%). Our clinicians had similar findings. Please refer to the **Transfers** indicator for more details.

Medication Administration

Compliance testing showed nurses administered TB medications within required time frames (MIT 9.001, 80.0%). However, the institution did not thoroughly monitor patients taking TB medications as required by policy (MIT 9.002, 15.0%). Our clinicians found nurses generally adminstered medications properly; however, they identified opportunities for improvement in medication administration:

- In case 15, the patient received antidepression medication five days late. Although the medication was a stock medication in the outpatient medication area, the nurses did not administer the medication timely.

Clinician On-Site Inspection

Our clinicians interviewed medication nurses and found them knowledgeable about the medication process. During the huddle, the care teams discussed medication compliance, including medication nonadherence and medication continuity for patients transferring into the institution or arriving from another yard. We also met with the pharmacist in charge and nurse managers to discuss some of our findings.

Compliance Testing Results

Medication Practices and Storage Controls

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

CCWF appropriately stored and secured nonnarcotic medications in nine of ten clinic and medication line locations (MIT 7.102, 90.0%). One location lacked a clearly labeled designated area for medications that were to be returned to the pharmacy.

Staff kept medications protected from physical, chemical, and temperature contamination in seven of the 10 clinic and medication line locations (MIT 7.103, 70.0%). In three clinics, staff did not store oral and topical medications separately.

Staff successfully stored valid, unexpired medications in eight of the 10 applicable medication line locations (MIT 7.104, 80.0%). In two clinics, medication nurses failed to label the multi-use medication as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in four of six locations (MIT 7.105, 66.7%). In two locations, some nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in five of six medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 83.3%). In one location, medication nurses did not maintain unissued medications in its original packaging.

In two of six medication areas, staff used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 33.3%). In four locations, medication nurses did not reliably observe patients while they swallowed direct observation therapy medications.

Pharmacy Protocols

Pharmacy staff followed general security, organization, and cleanliness management protocols in its main pharmacy (MIT 7.108, 100%). Staff properly stored nonrefrigerated (MIT 7.109, 100%) and refrigerated or frozen medications in its pharmacy (MIT 7.110, 100%).

The pharmacist in charge (PIC) did not thoroughly review monthly inventories of controlled substances in the institution's clinic and

medication storage locations. Specifically, the pharmacists and nurses present at the time of the medication area inspection did not correctly complete several medication area inspection checklists (CDCR Form 7477). These errors resulted in a score of zero in this test (MIT 7.111).

We examined 25 medication error reports. The PIC timely and correctly processed all of these reports (MIT 7.112, 100%).

Nonscored Tests

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

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. All ten applicable patients interviewed indicated they had access to their rescue medications (MIT 7.999).

Compliance Testing Results

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) *	2	16	7	11.1%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	17	8	0	68.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	4	10	3	28.6%
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) *	7	5	8	58.3%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	16	9	0	64.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	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)	8	0	2	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	9	1	0	90.0%
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)	7	3	0	70.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	2	0	80.0%
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)	4	2	4	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	5	1	4	83.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	2	4	4	33.3%
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)	25	0	0	100%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in 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): **67.8%**			

* 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) *	10	2	1	83.3%
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) *	16	4	0	80.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	3	17	0	15.0%
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) *	4	6	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.

Recommendations

- Medical and nursing leadership should identify the causes of the challenges to medication continuity for chronic care, hospital discharge, and specialized medical housing patients and implement remedial measures as appropriate.
- Medical and nursing leadership should ensure hospital discharge, reception center transfers, intra-facility transfers, chronic care, and newly ordered medications are timely ordered, made available, and administered to the patients without interruptions.
- Nursing leadership should consider reminding nursing staff to document patient refusals in medical administration records, as described in the CCHCS policy and procedures.

Prenatal and Postpartum Care

This indicator evaluates the institution's capacity to provide timely and appropriate prenatal, delivery, and postnatal services to pregnant patients. This includes the ordering and monitoring of indicated screening tests, follow-up visits, referrals to higher levels of care, for example, high-risk obstetrics clinic, when necessary, and postnatal follow-up.

Overall Rating
Proficient

Case Review Rating
Proficient

Compliance Score
Proficient
(100%)

Results Overview

CCWF performed very well in this indicator. OIG clinicians reviewed four cases and found care timely and appropriate in all cases with minimal deficiencies. Compliance testing showed the institution provided excellent prenatal and postpartum care. We rated this indicator ***proficient***.

Case Review and Compliance Testing Results

Our clinicians reviewed four cases and 23 events related to prenatal and postpartum care. All cases transferred to CCWF from county jails. We identified five minor deficiencies in cases 12, 13 and 14 related to incomplete nursing assessments. Overall, nurses conducted appropriate health screenings and made appropriate referrals. All patients received timely and appropriate prenatal care.

Prenatal Care

CCWF had excellent performance in prenatal care. Compliance testing found all patients received appropriate housing, vitamin and meal supplementation, and timely provider care (MITs 8.001, 8.002, 8.003, all 100%). Referrals to the obstetrician were timely and visits occurred within the required time frames. The medical staff always obtained patients' weights, blood pressures, and fundal heights (MITs 8.004 and 8.006, both 100%). Prenatal care was predominantly performed by on-site providers; however, when off-site services were necessary, they were provided within appropriate time frames. OIG clinicians did not find any significant deficiencies in prenatal care.

Postpartum Care

Only one case had postpartum care, and CCWF performed well with postpartum care for this patient. The patient arrived late in her pregnancy term and received proactive and appropriate care.

Clinician On-Site Inspection

OIG clinicians met with the on-site obstetrician-gynecologist, nursing staff, medical leadership, and scheduling staff. The provider saw patients on-site since telemedicine was not utilized during the COVID-19 pandemic. Having a skilled obstetrician-gynecologist was beneficial to both the institution and the patients. Especially during the COVID-19 pandemic, the retention of a board-certified specialist on-site greatly reduced the frequency of off-site appointments, improved access to care, provided excellent continuity of care, and reduced potential exposure of patients to COVID-19.

Compliance Testing Results

Table 16. Prenatal and Postpartum Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients identified as pregnant, did the institution timely offer initial provider visits? (8.001) *	3	0	0	100%
Was the pregnant patient timely issued a comprehensive accommodation chrono for a lower bunk and lower-tier housing and did the patient receive the correct housing placement? (8.002)	2	0	1	100%
Did medical staff promptly order recommended vitamins, extra daily nutritional supplements and food for the patient? (8.003) *	3	0	0	100%
Did timely patient encounters occur with an OB physician or OB nurse practitioner in accordance with the pregnancy encounter guidelines? (8.004) *	3	0	0	100%
Were the results of the patient's initial prenatal screening tests timely completed and reviewed? (8.005) *	3	0	0	100%
Was the patient's weight, fundal height, and blood pressure documented at each clinic OB visit? (8.006) *	3	0	0	100%
Did the patient receive her six-week postpartum obstetric visit? (8.007) *	0	0	3	N/A
Overall percentage (MIT 8): **100%**				

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

Recommendations

The OIG offers no recommendations for this indicator.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as high risk for coccidioidomycosis (valley fever), we tested the institution's ability to transfer out patients quickly. 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.

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(76.8%)

Results Overview

CCWF staff had mixed performance in preventive services. Staff performed well in administering TB medications as prescribed, offering patients an influenza vaccine for the most recent influenza season, offering colorectal cancer screening for all patients ages 50 through 75, offering mammogram, pap smear, and required immunizations to chronic care patients. The institution did not always monitor patients who were taking prescribed TB medication or screen patients annually for TB. We rated this indicator ***adequate***.

Compliance Testing Results

Table 17. 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)	16	4	0	80.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	3	17	0	15.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	15	10	0	60.0%
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)	24	1	0	96.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	25	0	0	100%
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	20	5	0	80.0%
Are required immunizations being offered for chronic care patients? (9.008)	15	3	7	83.3%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
Overall percentage (MIT 9): **76.8%**				

* 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 EHRS PowerForm for tuberculosis symptom monitoring.

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

Recommendations

- Nursing leadership and the public health nurse should educate nursing staff to fully document TB symptoms as part of the patient's TB medication monitoring.
- Nursing leadership and the public health nurse should educate nursing staff in timely and accurate monitoring of patient's annual TB screening per CCHCS policy.

Nursing Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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

CCWF delivered satisfactory nursing care. Compared with Cycle 5, the institution improved in chronic care management. The institution's population management sessions provided multidisciplinary collaboration in the care of patients with chronic conditions. However, nurses continued to show opportunities for improvement in assessments and emergency care for patients with urgent symptoms. Overall, these deficiencies did not significantly impact the patient care provided. Therefore, OIG rated this indicator ***adequate.***

Case Review Results

We reviewed 425 nursing encounters in 47 cases. Of the nursing encounters we reviewed, 324 were in the outpatient setting. We identified 97 nursing performance deficiencies, 16 of which were significant.[31]

Nursing Assessment and Interventions

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

[31] Deficiencies occurred in cases 1, 2, 3, 4, 6, 8, 9, 10, 11 ,13 ,15 ,16, 17, 18, 19, 20, 32, 33, 34, 36, 39, 41, 45, 47, 48, 49, 50, 51, 52, 53, 54, and 55. Significant deficiencies occurred in cases 1, 3, 4, 6, 9, 17, 32, 33, 34, 36, 39, 47, 51, and 52.

objective (observation and examination) elements. CCWF nurses generally provided adequate nursing assessments and interventions. However, nursing assessment, documentation, and plans of care had room for improvement in the transitional care unit (TCU).

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in a patient's condition. Nursing documentation of care provided was good in specialty, prenatal and postpartum care, and reception center assessments. In contrast, our clinicians identified opportunities to improve nursing documentation in the TCU, specialized medical housing (SMU), emergency services, and hospitalization.

Nursing Sick Call

Our clinicians reviewed 107 sick call requests. Most nurses reviewed symptomatic sick call requests appropriately and saw patients timely. However, we identified 15 significant deficiencies related to incomplete assessments, not consulting the provider of urgent symptoms, and not evaluating patients the same day for possible emergent conditions. The examples below demonstrate room for improvement our clinicians identified in the case reviews:

- In case 1, the patient complained of yellow skin (jaundice), fatigue for two to three days, and diarrhea for two months. The sick call nurse did not perform a complete abdominal and skin assessment for the patient or take orthostatic vital signs (vital signs performed while in three different positions). In addition, the nurse did not address the patient's weight loss of 11 pounds.

- In case 9, the patient with a recent history of stroke complained of dizziness, nausea, and heart palpations. The nurse did not assess the patient the same day, auscultate patient's heart sounds, or consult with the provider for additional orders, such as order a follow-up provider appointment or an EKG.

- In case 17, the patient complained of not having a bowel movement for two weeks. The sick call nurse did not take the patient's vital signs, complete an abdominal assessment, or review the patient's medication compliance.

- In case 39, the patient submitted a sick call request for a possible allergic reaction to glaucoma eye drops. The sick call

nurse did not see the patient the same day the sick call slip was reviewed.

Care Management/Coordinator

Our clinicians reviewed 34 events for care management and found nurses generally performed appropriate assessments and interventions for patients with chronic conditions. However, in two cases the certified nursing assistant (CNA) completed vital signs for a TCU patient, but did not report the abnormal findings to the RN or the provider.[32]

Wound Care

We reviewed four cases in which wound care was provided for the patients and found nurses did not always complete wound care as ordered. In one case we found a minor opportunity for improvement in assessment of the wound size for a patient in the correctional treatment center (CTC). In another case, we identified two significant deficiencies:

- In case 1, wound care was not completed as ordered on five of the 10 days wound care was ordered. On multiple occasions, the provider noted the biliary drain was leaking, wanted dressing changes done more often, and notified nursing to perform wound care. On one occasion, the provider ordered zinc ointment for the patient because the patient's skin was irritated.

Emergency Services

We reviewed 16 urgent or emergent cases. Our clinicians found first medical responders responded promptly. However, we identified incomplete reassessments and interventions, delayed notification to providers of abnormal vital signs and assessment findings, and inappropriate discharges to housing for patients presenting with urgent symptoms. These findings are detailed further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 12 cases in which patients returned from a hospitalization or an emergency room. The nurses generally provided good nursing assessments for these patients. This is detailed further in the **Transfers** indicator.

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[32] Deficiencies occurred in cases 9 and 17.

Transfers

Our clinicians reviewed 10 cases that involved the transfer-in or transfer-out processes at CCWF. Nurses evaluated patients within the required time frames. However, in one case the nurse did not test the blood sugar of the diabetic patient upon arrival. Please refer to the **Transfers** indicator for further details on these findings.

Reception Care

Nurses had mixed performance in reception care. Compliance testing found nurses did not always complete the initial health screening forms thoroughly. However, nurses did sign and complete the assessment and disposition portion of the health screening timely. Our clinicians did not identify any significant deficiencies. More details are available in the **Reception Center** indicator.

Prenatal and Postpartum Care

We reviewed 23 events related to prenatal and postpartum care in four cases. CCWF nurses provided good perinatal screening assessments and postpartum assessments within required time frames. We found minor opportunities for improvement in assessments and documentation.[33] However, the deficiencies did not impact the patient care provided.

Specialized Medical Housing

Our clinicians reviewed 29 events in five cases. The nurses provided satisfactory assessments but showed room for improvement in documentation. We discuss these finding in more detail in the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 14 cases in which patients received specialty procedures and consultations. Nurses performed good assessments, reviewed specialist findings and recommendations, and communicated results to the provider. The **Specialty Services** indicator provides further information.

Medication Management

After reviewing 25 cases, our clinicians found nurses generally administered medications to patients as prescribed. However, we found incomplete medication reconciliation for patients returning from the

[33] Deficiencies occurred in cases 12, 13, and 14.

hospital. We also found nurses failed to administer medications, reporting that medications were not available. During our on-site inspection, we found that the medications were regularly stocked in the nursing station. The **Medication Management** indicator provides further information.

Clinician On-Site Inspection

Our clinicians spoke with nurse instructors and the nurses in the TTA, SNF, R&R, TCU, specialty, outpatient clinics, and medication areas. We attended organized huddles and population management working sessions. We found clinical staff knowledgeable and familiar with their patient population.

Our clinicians were impressed by CCWF's population management session and the multiple disciplines that were present and contributed to the discussion. The population meeting was well-structured and organized. The team was knowledgeable of their patient population and coordinated the management of diabetic patients with dietary, mental health, and medical staff. In addition, the specialty nurse reviewed the vaccine registry, provided updates for varicella screening appointments, and ordered follow-up appointments for refusals.

In response to the COVID-19 pandemic, the institution established the incident command post in the late summer of 2020. The director of nursing (DON) oversaw operations while the CNE gave direction from the command post. The institution reported that the information disseminated from CCHCS headquarters to the institution's leadership was not always clear. In response, the institution's leadership provided clear direction and training locally. All nursing supervisors interviewed stated they also assisted with patient care in their areas of supervision. The nursing staff stated they felt supported by the nursing supervisors, especially when staffing was low, as they would assist with patient care.

Recommendations

- Nursing leadership should consider refresher training for providers on the requirement that all transitional care unit admissions have a detailed plan of care with measurable objectives.
- Nursing leadership shoulder remind certified nursing assistants to report abnormal vital signs to a registered nurse or provider.

Provider Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

In this indicator, OIG case review clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. Our clinicians assessed the institution's providers' 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. We assessed provider care through case review only and performed no compliance testing for this indicator.

Results Overview

CCWF providers delivered adequate care. Of the 26 cases reviewed by the OIG clinicians, 23 were adequate and three were inadequate. In Cycle 5, this indicator was inadequate due to pervasive issues with poor provider medical decision making, failure to examine patients, failure to order medically appropriate follow-ups, and poor review of records. While some problems persisted, the OIG clinicians saw improvement overall. Strengths identified in Cycle 6 were continuity of care, willingness of the providers to see their patients during the COVID-19 pandemic, and participation in robust population management meetings. We rated this indicator ***adequate.***

Case Review Results

The OIG clinicians examined the care quality in 26 comprehensive case reviews. We found a total of 69 provider performance deficiencies, 21 of which were significant, spanning five cases.[34]

Assessment and Decision-Making

CCWF providers generally made appropriate assessments and sound medical plans for their patients. They diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to proper specialists. However, the majority of the deficiencies involved the same three providers.[35] The OIG noted areas of excellent and good care by other providers, and even good care by these providers at times.

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[34] Deficiencies were noted in cases 1, 2, 3, 6, 9, 10, 12, 15, 33, 34, 36, 38, 39, and 47. Significant deficiencies were noted in cases 1, 3, 10, 34, and 36.

[35] Assessment and decision-making deficiencies occurred in cases 1, 3, 6, 9, 10, 12, 15, 33, 34, and 36. Significant deficiencies occurred in cases 1, 3, 10, 34, and 36.

The following are examples our clinicians found of poor assessment and decision making:

- In case 1, the outpatient clinic provider did not order specialty follow up as required, ordered diabetic follow up laboratory work for three months when it should have been ordered sooner, and did not recognize the patient had lost over 18 pounds in five months. The patient was later diagnosed with terminal cancer.

- In case 10, the high-risk patient complained of syncopal episodes, which can be a harbinger of life-threatening cardiac or neurologic conditions. The provider stated the patient's episodes were due to low blood sugars without performing an adequate history, review of systems, physical exam, or diagnostic tests to rule out other more serious causes.

- Also, in case 10, the provider reviewed a red blood cell count test result that had dropped significantly which could indicate the patient had internal bleeding or unknown cause of red blood cell destruction. The provider acknowledged the laboratory result but ordered no further tests, and did not rule out serious causes.

CCWF prenatal and postpartum provider performance was excellent, as noted earlier in the **Prenatal and Postpartum care** indicator. An additional example of exemplary care by the obstetrician-gynecologist on-site provider was noted:

- In case 15, the provider's diligence and proactive care was an important factor in diagnosis and treatment of a gynecologic cancer that may have saved the patient's life. The provider went over and above to provide this patient care and ensured the patient received the specialty care she needed.

Review of Records

Usually providers reviewed records appropriately; however, we found that errors were made on return from hospitalizations and on specialty follow ups. These are discussed further in the **Access to Care, Transfers**, and **Specialty Services** indicators.

Emergency Care

CCWF providers usually made appropriate triage decisions when patients arrived in the TTA for emergency treatment. In addition, providers were available for consultation with the TTA nursing staff. We found two significant emergency care deficiencies; however, both

were attributed to one provider and is discussed in the **Emergency Services** indicator.

Chronic Care

In most instances, the CCWF providers appropriately managed their patient's chronic health conditions including hypertension, asthma, hepatitis C infection, and cardiovascular disease; however, we identified a pattern of providers not making appropriate diabetes medication adjustments. There was also a pattern of providers sending patient results letters on chronic care concerns stating that their laboratory results were normal or unchanged, and that no follow up was required. This was concerning because even when the laboratory results were unchanged, they frequently were not normal, and required follow up, which could lead patients to believe their uncontrolled conditions were controlled.

Only one anticoagulation patient was identified and was managed appropriately.

Specialty Services

Most CCWF providers appropriately referred and reviewed specialty reports in a timely manner. Our clinicians identified nine specialty deficiencies related to provider performance. Six of these deficiencies were due to providers not following specialist's recommendations, of which three were considered significant. In two of the three significant deficiencies, the provider did not order specialty services that were needed.[36] We discuss these findings in more details in the **Specialty Services** indicator.

Documentation Quality

Most CCWF providers usually documented outpatient and TTA encounters; however, our clinicians identified 21 deficiencies related to no or poor documentation of outpatient care. Many of these deficiencies were attributed to a small number of providers. We found instances of providers making significant medical decisions but not documenting reasons for these decisions.

The **Health Information Management** indicator provides more information on these findings.

[36] Deficiencies occurred in cases 1, 10, 34, and 38. Significant deficiencies occurred in cases 1,10, and 34.

Provider Continuity

Provider continuity was generally very good. The permanent providers had been assigned to their yards for an extended period of time. Usually, the provider who ordered diagnostics or specialty services was the same provider who reviewed the documents, saw the patient in follow up, or recommended the treatment plan.

Clinician On-Site Inspection

OIG clinicians met with all levels of medical leadership and staff during the on-site inspection and attended well-organized morning huddles at the two main clinics.

Medical leadership explained that providers are generally assigned to a clinic for two years, which supports continuity of provider care. CCWF employs physicians and nurse practitioners.

The providers expressed job satisfaction and good morale. Some providers reported that their nursing resources frequently changed, at times daily, creating frequent interruptions to their clinics and disrupting patient care activities which could possibly lead to medical errors. Otherwise, resources were available for patient care.

The COVID-19 pandemic represented significant patient care and staff challenges. The institution was relatively free of COVID-19 early in the pandemic and worked under the CCHCS headquarters phase plan which included patient movement restriction, frequent testing, isolation and quarantine as needed, and staff modifications to meet space and exposure requirements. CCWF experienced COVID-19 cases in July and August 2020.The most significant surge with over one thousand cases occurred in December, with daily COVID-19 cases in the hundreds occurring for several months afterward.

According to medical leadership, in order to comply with early CCHCS COVID-19 guidance, one half of the providers worked remotely from home and the other half worked on-site. The groups alternated weekly between remote and on-site work. When the guidance for high-risk providers was released, six of the nine providers were determined to be high risk and were given opportunities to continue to work from home. We were advised that while on modified work schedules, providers reviewed daily clinic lists for triage, prioritizing urgent and emergent appointments. Early in the pandemic, following CCHCS guidelines, providers usually deferred chronic care appointments and performed chart review rather than conduct face-to-face visits. Once vaccinations were available, most providers returned on-site.

During our case review, OIG clinicians found that providers did see patients throughout the pandemic; however, most visits were via electronic interface and frequently the physical exams were not completed properly. At the on-site visit, medical leadership advised they did make attempts to use CCHCS formal telemedicine equipment, as connectivity issues between the telemedicine systems and provider at-home equipment prevented this. The most frequently described approach was a clinic system comprised of a tablet, laptop, or desktop affixed with a camera that the provider would use to visualize the patients through a remote laptop they had at home. Medical leadership said they also attempted to connect electronic stethoscopes to the laptops, but technical issues arose that could not be corrected. There were no peripheral devices available on these units, so heart and lung, detailed dermatologic, and ears, nose, and throat examinations could not be directly performed. Also, the only staff in the examination room with the patient were medical assistants, who were not trained or licensed to perform physical examinations, further limiting examination capability. According to providers, if a more detailed, urgent physical examination was needed, the clinic RN could assist in the examination or an appointment could be made in an on-site clinic or TTA; however, the RNs also had significant clinic responsibilities during clinic hours. Although this solution limited physical examination capabilities, the OIG applauds CCWF and the efforts of its providers to see the patients and address clinical issues, despite the movement and technology restrictions caused by the COVID-19 pandemic policies.

Our clinicians observed one clinic's population management session during our on-site visit. Medical and nursing leadership, providers, nurses, and ancillary services and mental health staff worked well together to address patients' chronic care conditions. The providers were knowledgeable about patients assigned to their patient panel and provided direction regarding the overall management of their chronic care patients. Polypharmacy and complex patients were reviewed during these meetings as well.

The chief medical executive (CME) and acting chief physician and surgeon (CP&S) were highly respected. At the time of our inspection, the CP&S informed us she had accepted a position with headquarters and was the "acting" CP&S. The providers expressed significant appreciation for the guidance and support both the CME and CP&S provided.

Recommendations

- Medical leadership should consider specific training on improved documentation and monitored medical decision making for providers who have the most deficiencies in our case reviews.

Reception Center

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the CDCR system. The OIG review evaluates the institution's ability to provide and document initial health screenings and health assessments, continuity of medications, and completion of required screening tests, as well as its ability to address and provide significant accommodations for disabilities and health care appliance needs and to identify health care conditions needing treatment and monitoring. The patients reviewed for reception center cases are those received from facilities that are not connected with the department, such as county jails.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate (75.0%)

Results Overview

CCWF delivered acceptable care. The R&R nurses assessed the patients timely, reviewed health records from county jails, made appropriate referrals to providers, and ensured all patients were placed in quarantine for COVID -19 precautions. Compared with Cycle 5, CCWF significantly improved in timely provider appointments for patients for the health and physical (H&P) within seven days. Overall, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed four cases and identified five deficiencies.[37]

Provider Access

Compliance testing showed patients always received a history and physical (H&P) examination by a provider within seven days, as required by policy (MIT 12.004, 100%). Intake screening tests were frequently offered or completed within the required time frames (MIT 12.005, 90.0%). Likewise, case review did not find any deficiencies with provider access.

Nursing Performance

Compliance testing found that the nurses did not complete the initial health screening forms thoroughly (MIT 12.001, zero). The nurses did not address the signs and symptoms of fatigue when screening for TB. However, the R&R nurses timely signed and completed the assessment and disposition portion of the health screening form (MIT 12.002, 100%). Our clinicians reviewed four cases of patients

[37] Deficiencies occurred in cases 11,12, and 13.

arriving via the reception center and found five deficiencies, none of which were significant.

Our clinicians found the nurses appropriately assessed and referred patients to providers; however, there were minor deficiencies in three cases, which did not negatively impact patient care.

Clinician On-Site Inspection

The nurses our clinicians interviewed were knowledgeable about their job duties and the reception intake process. We met with the nurse manager who shared with us CCWF's current process of screening patients for COVID-19 received from county jails.

Early in the COVID-19 pandemic, the institution established a command center to better manage the COVID-19 outbreak. CCWF assigned the CNE to act as the health care incident commander. At the time of our on-site inspection, the CNE remained in this role, receiving a list of patients scheduled to arrive to CCWF from the county jail and reviewing the medical records with COVID-19 test results. Patients are prescreened prior to arrival from the county jail. This process includes review of the medical records and COVID-19 test results to determine which patients will transfer to CCWF. The R&R staff is notified of the patients arriving and chart reviews are completed ahead of time to prepare for the arrival of the patients. Upon arrival to CCWF, custody and medical staff, wear full PPE before contact with the patient. Thereafter, patients are placed in quarantine for 14 days.

Compliance Testing Results

Table 18. Tests Related to Reception Center

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
For patients received from a county jail: Prior to 4/2019: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution? Effective 4/2019: Did nursing staff complete the initial health screening and answer all screening questions upon arrival of the patient at the reception center? (12.001) *	0	20	0	0
For patients received from a county jail: Prior to 4/2019: When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening? Effective 4/2019: Did the RN complete the assessment and disposition section, and sign and date the completed health screening form upon patient's arrival at the reception center? (12.002) *	15	0	5	100%
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) *	1	0	19	100%
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) *	20	0	0	100%
For patients received from a county jail: Were all required intake tests completed within specified timelines? (12.005) *	18	2	0	90.0%
For patients received from a county jail: Did the primary care provider review and communicate the intake test results to the patient within specified timelines? (12.006)	7	13	0	35.0%
For patients received from a county jail: Was a tuberculin test both administered and read timely? (12.007)	20	0	0	100%
For patients received from a county jail: Was a Coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely? (12.008)	0	0	20	N/A
			Overall percentage (MIT 12):	**75.0%**

* 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 19. Other Tests Related to Reception Center

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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) *	7	5	8	58.3%

* 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.

Recommendations

- The department should consider developing and implementing an electronic alert to ensure nurses in the R&R clinic complete initial health screening questions and follow up with patients as needed.

Specialized Medical Housing

Overall Rating ***Adequate***

Case Review Rating **Adequate**

Compliance Score **Adequate (77.5%)**

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. Our clinicians also interpreted relevant compliance results and incorporated them into this indicator. At the time of our inspection, the CCWF specialized medical housing consisted of a skilled nursing facility (SNF).

Results Overview

CCWF providers and nurses delivered satisfactory care to patients in the skilled nursing facility (SNF). Nurses performed routine patient assessments and provided interventions appropriately. Compared with Cycle 5, CCWF had a slight decline in medication continuity, timely provider history and physical assessments, and nursing assessments and documentation of patient care. However, these findings did not impact the patient care that was provided. Therefore, we rated this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 1,363 SNF events, including 49 provider and 29 nursing events. Because of the care volume that occurs in specialized medical housing units, each provider and nursing event represents up to one month of provider care and two weeks of nursing care. We identified 46 deficiencies, 10 of which were significant.[38]

Provider Performance

Provider performance in the SNF was adequate. Of the 133 events our clinicians reviewed, 84 were related to provider encounters, orders, or review of laboratory results, and involved six cases. Most cases were handled well by providers, and patients received adequate medical care. Our clinicians identified 13 deficiencies.[39] Six of the deficiencies were significant, with four occurring in case 1:

[38] Deficiencies occurred in cases 1, 3,15, 33, and 36. Significant deficiencies occurred in case 1, 3, and 36.

[39] Significant deficiencies occurred in cases 1, 3, and 36.

- In case 1, the patient was diagnosed with a terminal illness. Prior to being placed on hospice care, the patient's kidney function worsened, which the providers in the SNF did not address on multiple occasions. While the patient was on hospice care, the providers requested intravenous fluids and the implementation of comfort care measures; however, these were not completed.

- In case 3, the patient, who had a history of significant vision-threatening eye conditions, complained of blurred vision. The provider did not see the patient and an eye exam or vision test was not performed.

- In case 36, the patient had a history of cardiac condition, which could lead to fast, chaotic heart beats. The provider placed the patient on a medication that can cause or worsen this cardiac condition, even though a previous provider had discontinued the same medication.

Compliance testing found providers performed admission histories and physical examinations within required time frames only 70.0 percent of the time (MIT 13.002). OIG clinicians reviewed SNF events in six cases, four of which had new admissions during the review period, and found admission history and physical examinations were performed timely and documented thoroughly.

Nursing Performance

Compliance testing found SNF nurses performed timely admission assessments (MIT 13.001, 100%). Case reviews also showed the nurses completed admission assessments timely. SNF nurses conducted regular rounds and generally provided satisfactory care. However, our clinicians found opportunities for improvement in nursing assessments, wound care, and reassessments after "as needed" medications were administered and provided wound care was documented:

- In case 1, wound care was not completed as ordered for a biliary catheter drain on several occasions. In a progress note, the provider described the patient's dressing as completely soaked and wanted the dressing changes done more often.

- In case 3, the patient had an abnormally elevated blood pressure. The certified nursing assistant (CNA) did not report this finding to the RN. The RN on the next shift notified the provider five hours later of the abnormal blood pressure. In addition, nursing assessments were incomplete, and nurses did not reassess the effectiveness of the "as needed" pain medication.

- In case 15, the patient had a foley catheter after a hysterectomy procedure. SNF nurses did not perform catheter care as ordered by the provider. In addition, the nurses did not perform complete documentation for the intake and output for a patient with a catheter.

Medication Administration

Our clinicians found most patients received their medications within the required time frames. Compliance testing showed 40.0 percent of newly admitted patients received their medication within required time frames (MIT 13.004). In half of the noncompliant samples we tested, patients did not receive "as needed" rescue medication when the provider ordered it.

Clinician On-Site Inspection

The institution's SNF had 26 beds, including two negative pressure rooms. At the time of our inspection, 18 beds were occupied. Our compliance testing found that the call light system was functional and working. The institution's SNF had two designated providers, one full-time and the other part-time. Both performed rounds with nursing staff. Nurses provided 24-hour care at the SNF.

In the SNF, the provider generally sees the patient once a month and more frequently for condition changes and as needed. Patients notify the nurses of any complaints. New changes in the patient conditions are discussed in the huddle, where the provider determines when the patients should be seen.

SNF staff reported that during the COVID-19 pandemic, the COVID-19 vaccinations were prioritized for the SNF patients. California Department of Public Health (CDPH) staff assisted CCWF in helping to manage COVID-19 cases.

Compliance Testing Results

Table 20. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	10	0	0	100%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	7	3	0	70.0%
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	10	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) *	4	6	0	40.0%
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): **77.5%**				

* 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

Recommendations

- Nursing leadership should ensure nurses in the skilled nursing facility (SNF) thoroughly assess patients and document the assessments along with wound care.
- Nursing leadership should ensure nurses initiate care plans and reassess patients at regular intervals.

Specialty Services

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(75.9%)

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.

Results Overview

CCWF provided adequate specialty services for their patients. Compared with Cycle 5, CCWF improved in following specialist recommendations. However, a few providers did not order specialty follow-up appointments timely, did not follow specialist recommendations, and did not document their medical reasoning, causing delays in specialty care for affected patients. CCWF performed well with high- and medium-priority access despite the COVID-19 pandemic. The OIG ultimately rated this indicator ***adequate.***

Case Review and Compliance Testing Results

The OIG clinicians reviewed 171 events related to specialty services, including 90 specialty encounters, 27 nursing encounters, and 16 provider encounters. Of the 90 specialty encounters, 51 were related to off-site or telemedicine specialty visits and required provider follow-up. Of the 171 specialty service events, we found 32 deficiencies, nine of which were significant.[40] Obstetrics or gynecology visits, which were performed by most primary care providers, were not included as specialty consultations. Due to the COVID-19 pandemic, we found many specialty visits were deferred, but a large proportion were reviewed and most critical and urgent specialty care was provided.

Access to Specialty Services

CCWF performed well in completing most high-priority, medium-priority, and routine-priority specialty appointments within required time frames (MIT 14.001, 100%, MIT 14.004, 86.7% and MIT 14.007, 80.0%). For patients arriving from another CDCR institution, only 50.0 percent of the patients' specialty appointments occurred within the required time frames (MIT 14.010); however, this compliance test only had a sample size of two patients. OIG case reviewers found four access

[40] Deficiencies were noted in cases 1, 2, 3, 7, 9, 10, 15, 17, 19, 32, 33, 34, 36, and 38. Significant deficiencies occurred in cases 1, 10, 17, 34, 36, and 38.

deficiencies, three of which were significant. The deficiencies were all related to delayed follow-up appointments. These are discussed in more detail in the **Access to Care** indicator.

Compared with Cycle 5, CCWF improved in providing adequate physical therapy services; inpatient physical therapy continued seeing patients, despite the COVID-19 pandemic. CCHCS dietary consultations and obstetrics-gynecology care were also available throughout the review period.

Provider Performance

CCWF providers performed poorly in the specialty services indicator. In Cycle 5, providers often had problems making appropriate referrals to a specialist and delayed or overlooked specialty recommendations. OIG clinicians found this problem continued in Cycle 6, but was isolated to a few providers. Compliance testing showed providers saw patients for required post-specialty follow-up 90.5 percent of the time (MIT 1.008).

While most CCWF providers appropriately referred and reviewed specialty reports timely, they did not always follow specialty recommendations. OIG clinicians reviewed 38 provider visits that involved specialty consultation follow-up. Of the 38 visits, OIG clinicians identified seven deficiencies. Five of the seven deficiencies were due to providers not following specialty recommendations, three of which were significant.[41] The providers did not document reasons for not following the specialist recommendations. Additionally, two significant deficiencies were due to providers not ordering necessary specialty services:

- In case 1, the patient had a history of a precancerous esophagus condition and enlarged esophageal veins, which can lead to life-threatening bleeding. The specialist recommended repeat stomach and esophageal endoscopy[42] in one to two years to monitor and ensure the conditions were not worsening. The provider saw the patient but did not order the study.

- In case 10, the kidney specialist recommended treatment for the patient's elevated potassium. The provider endorsed the specialist note and stated recommendations would be ordered at the provider follow-up visit. This follow-up visit did not

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[41] Deficiencies occurred in case 10, 34, and 38. Significant deficiencies occurred in cases 10 and 34.

[42] An endoscopy is a procedure where a medical scope is placed through the mouth into the stomach to visualize the esophagus and stomach.

occur, and the recommended orders were not written timely. Three months later, the kidney specialist again saw the patient and again recommended the medication to treat the elevated potassium be ordered for the patient, along with other recommendations. The provider again did not follow the specialist's recommendations. The patient was hospitalized shortly thereafter for elevated potassium.

- In case 34, the provider saw the patient for cardiology follow-up. The provider did not order the recommended follow-up testing and ordered a dose of medication four times larger than the dose that specialist recommended. Following the specialist's recommendation was critical because the patient had a history of low heart rate on this medication.

Nursing Performance

CCWR's nursing performance in specialty services was adequate. OIG clinicians identified 10 deficiencies, one which was significant.[43] Nurses did not always properly evaluate, assess, and educate patients returning from off-site appointments. This is discussed further in the **Nursing Performance** indicator.

Health Information Management

CCWF performed adequately in ensuring high-priority specialty reports were received, but poorly in ensuring medium- and routine-specialty reports were received and reviewed within CCHCS policy time frames (MIT 14.002, 80.0%, MIT 14.005 46.7% and MIT 14.008 71.4%). The OIG clinicians identified 10 specialty deficiencies related to health information management out of 84 events, only one of which was significant:[44]

- In case 38, the cancer specialist recommended computed tomography (CT) imaging, laboratory work, and a follow-up in two weeks. Several errors occurred in this case, including failure to complete imaging and laboratory work timely and to complete the follow-up with the cancer specialist in two weeks.

Compliance testing found CCWF had adequate performance in scanning high- and medium-priority specialty consultation reports timely (MIT 4.002, 80.0%). OIG clinicians found three of 10 specialty deficiencies related to health information management were for

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[43] Deficiencies occurred in cases 2, 3, 15,19, 32, 36, and 38. A significant deficiency occurred in case 36.

[44] Deficiencies occurred in cases 2, 7, 9, 17, 33, 36, and 38. A significant deficiency occurred in case 38.

misfiling specialty consultation reports; however, most specialty reports were endorsed timely. These findings are discussed further in the **Health Information Management** indicator.

Clinician On-Site Inspection

OIG clinicians met with CCWF managers, supervisors, providers, and utilization management nursing staff and discussed specialty referral management. During the review period, the COVID-19 pandemic affected specialty scheduling. Fortunately, the institution was fully staffed during this time. According to CCWF, their backlog was due to Phase 1 COVID-19 restrictions per CCHCS COVID-19 guidance, in which many specialty types were not available or had restricted clinics such as gastroenterology, optometry, and ophthalmology.

Medical leadership reviewed outstanding specialty appointments and determined what could be postponed. We were advised only urgent and emergent appointments were being processed and that care teams were messaged about postponements. In addition, the providers reviewed outstanding appointments for patients in quarantine and isolation to determine if the appointment must be kept, postponed, or cancelled. Specialty schedulers reported keeping a binder outside of the EHRS to track which referrals were outstanding. They also tracked the status of outstanding specialty consultation reports and results on an Excel spreadsheet.

Several of the misfiling errors the OIG case reviewers found were not identified by the health information management staff. However, staff corrected them after the OIG notified them of the errors.

Compliance Testing Results

Table 21. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	15	0	0	100%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	4	4	7	50.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	0	9	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	12	3	0	80.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	10	4	1	71.4%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	5	2	8	71.4%
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) *	1	1	0	50.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	15	1	0	93.8%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	13	3	0	81.3%
Overall percentage (MIT 14): 75.9%				

* 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 22. Other Tests Related to Specialty Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	38	4	3	90.5%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	24	6	15	80.0%

* 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.

Recommendations

- Medical leadership should ensure providers follow specialty recommendations and, if not, that providers document medical reasoning.
- Medical leadership should ensure patients receive their ordered follow-up specialty appointment services timely.

Administrative Operations

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We reviewed and determined whether 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.

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate (71.2%)

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.

Results Overview

CCWF had mixed performance in this indicator. The institution scored well in most applicable tests; however, a few areas had room for improvement. The EMMRC had incomplete checklists. At the time of our on-site inspection, we found the physician managers did not always complete annual performance appraisals timely. In addition, nurse educators completed onboarding for newly hired nurses late. We rated this indicator ***inadequate***.

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. Two unexpected (Level 1) deaths and one expected (Level 2) death 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 CEO within seven calendar days of completion. In our inspection, we found the DRC did not complete all three death review reports promptly; the DRC finished three reports

between 52 and 132 days late, and submitted them to the institution's CEO between five and 65 days late (MIT 15.998).

Compliance Testing Results

Table 23. 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)	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	2	10	0	16.7%
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)	3	1	0	75.0%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	3	0	0	100%
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)	1	2	0	33.3%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	0	12	0	0
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)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	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): 71.2%				

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

Recommendations

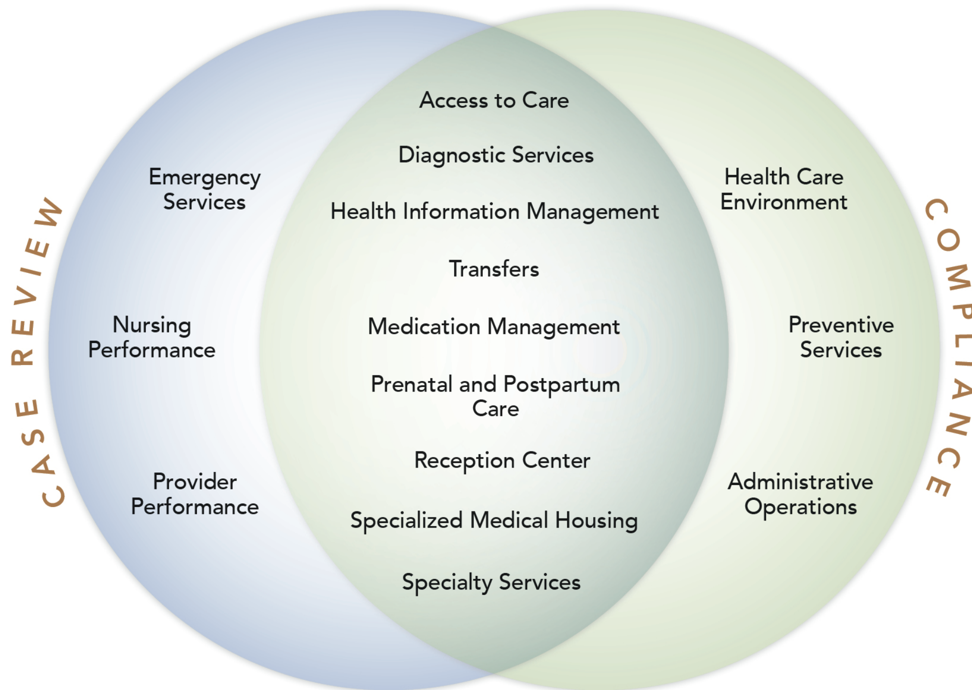
The OIG offers no specific recommendations for this indicator.

Appendix A: Methodology

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

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

Figure A–1. Inspection Indicator Review Distribution for CCWF



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

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

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

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

Case Review Sampling Methodology

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

After applying filters, analysts follow a predetermined protocol and select samples for clinicians to review. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

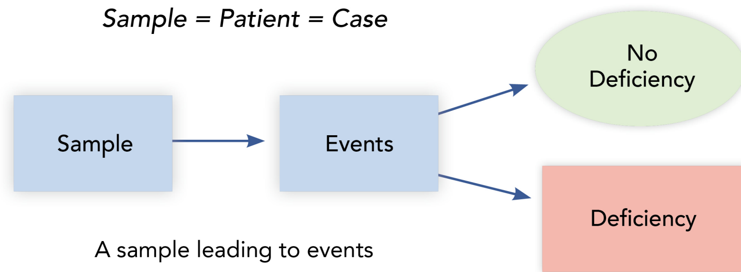
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

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

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

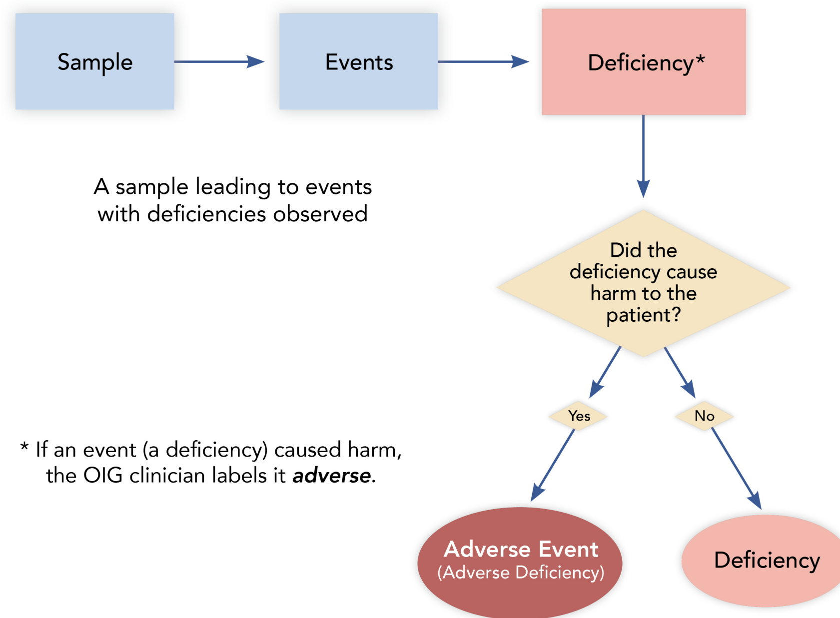
Figure A–2. Case Review Testing

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



Deficiencies

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



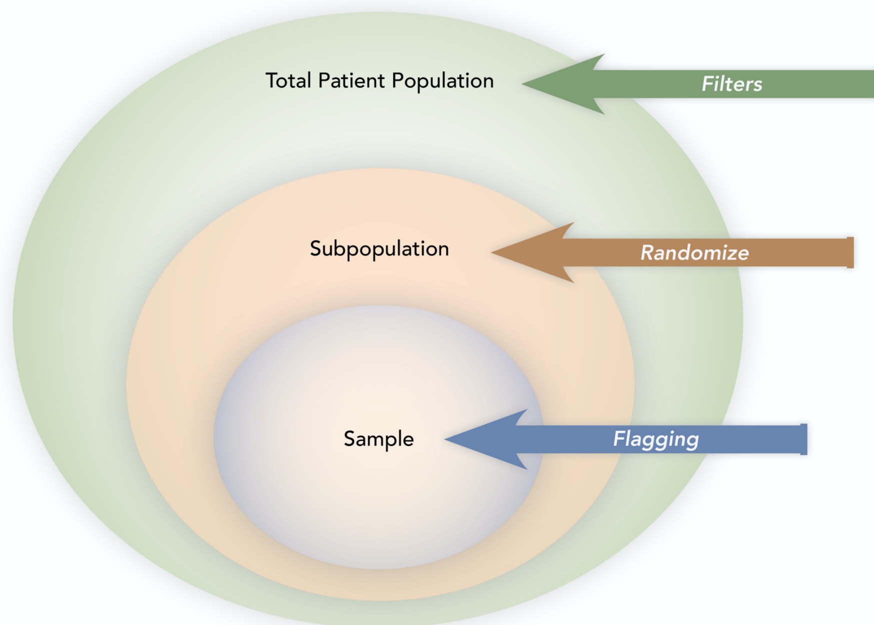
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A–3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

Our compliance team calculates the percentage of all Yes answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: ***proficient*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

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. CCWF Case Review Sample Sets

Sample Set	Total
Anticoagulation	1
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – Non-CPR	3
High Risk	6
Hospitalization	3
Intrasystem Transfers In	3
Intrasystem Transfers Out	2
Perinatal Services	4
RN Sick Call	16
Specialty Services	4
	48

Table B–2. CCWF Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	4
Anticoagulation	3
Arthritis/Degenerative Joint Disease	6
Asthma	13
COPD	1
COVID-19	9
Cancer	5
Cardiovascular Disease	5
Chronic Kidney Disease	3
Chronic Pain	12
Cirrhosis/End-Stage Liver Disease	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	13
Gastroesophageal Reflux Disease	9
Hepatitis C	7
Hyperlipidemia	8
Hypertension	20
Mental Health	20
Migraine Headaches	3
Rheumatological Disease	1
Seizure Disorder	3
Sleep Apnea	2
Substance Abuse	13
Thyroid Disease	7
	169

Table B–3. CCWF Case Review Events by Program

Diagnosis	Total
Diagnostic Services	387
Emergency Care	76
Hospitalization	45
Intrasystem Transfers In	13
Intrasystem Transfers Out	7
Outpatient Care	749
Prenatal and Postpartum Care	23
Reception Center Care	12
Specialized Medical Housing	133
Specialty Services	172
	1617

Table B–4. CCWF Case Review Sample Summary

MD Reviews Detailed	26
MD Reviews Focused	0
RN Reviews Detailed	17
RN Reviews Focused	19
Total Reviews	62
Total Unique Cases	48
Overlapping Reviews (MD & RN)	14

Appendix C. Compliance Sampling Methodology

Central California Women's Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	13	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	17	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	30	OIG Qs: 1.004	• Nondictated documents • First 20 Ips for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 Ips for each question
MIT 4.003	Hospital Discharge Documents	17	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	17	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	10	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	13	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	17	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	20	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	0	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	3	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	20	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	25	SOMS	• Arrival date (at least 2 yrs. Prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	25	SOMS	• Arrival date (at least three yrs. Prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	Reception Center	20	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	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

MIT 14.010	Specialty Services Arrivals	2	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	16	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events (ASE)	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	3	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	12	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)
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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
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	3	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services death reviews

California Correctional Health Care Services' Response

January 6, 2022

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

Dear Ms. Singh:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Central California Women's Facility (CCWF) conducted from August 2020 to February 2021. 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,

DocuSigned by:
Erin Hoppin
BCF902683938450...

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, Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
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Annette Lambert, Deputy Director, Quality Management, CCHCS
Regional Health Care Executive, Region II, CCHCS
Regional Deputy Medical Executive, Region II, CCHCS
Regional Nursing Executive, Region II, CCHCS
Chief Executive Officer, CCWF
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

Cycle 6

Medical Inspection Report

for

Central California Women's Facility

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
January 2022

OIG