May 10, 2016

Mark Bowen, Warden
Central Valley Modified Community Correctional Facility
254 Taylor Avenue
McFarland, CA 93250

Dear Warden Bowen:

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at Central Valley Modified Community Correctional Facility (CVMCCF) from January 11 through 12, 2016. The purpose of this audit was to ensure that CVMCCF is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On March 25, 2016, a draft report was sent to you providing the opportunity to review and dispute any findings presented in the draft report. On April 8, 2016, your facility submitted a response disputing 14 of the audit team's findings. The attached documents reflect 8 of the 14 items disputed which have been reconsidered. PPCMU's acceptance of eight rebuttal issues has not resulted in the removal of any items from the list of identified Critical Issues. Refer to the attached documents for the CCHCS's detailed response to questions and items disputed by CVMCCF.

After the release of the report on May 2, 2016, it was discovered that the report contained several uncorrected errors. Those errors have been corrected and are listed below.

Pages 16 & 17	Indicator #2 – Internal Monitoring & Quality Management
Pages 18 & 19	Indicator #3 – Licensing/Certifications, Training & Staffing
Page 22	Indicator #5 – Chronic Care Management
Page 28	Indicator #9 – Health Appraisal/health Care Transfer
Pages 33 & 34	Indicator #12 – Specialty Services
Page 38	Indicator #14 – Emergency Medical Response/Drills & Equipment
Page 40	Indicator #16 – Quality of Nursing Performance

Attached you will find the revised final audit report in which the overall audit rating of *inadequate* received by CVMCCF is unchanged. The report contains an executive summary table, an explanation of the methodology behind the audit, findings detailed by chapters of the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* and findings of the clinical case reviews conducted by CCHCS clinicians.

The audit findings reveal that during the audit review period, CVMCCF failed to provide adequate health care to CDCR patients housed at the facility. The facility's continued struggle with internal monitoring, specifically as it relates to the completion and submission of the weekly and monthly monitoring logs, patient's access to care, chronic care management, diagnostic services, health appraisal/health care transfer process, specialty services and emergency medical response training drills and maintenance of the emergency

medical response equipment, has resulted in barriers that prevented patients from receiving adequate level of care.

Additionally, the facility continues to struggle with insufficient documentation and lack of staff training, making it a challenge to provide quality care to its patient population. Out of the four outstanding critical issues identified in the January 2015 audit, two have been unresolved for over 18 months. All the outstanding and current deficiencies require the facility's immediate attention and resolution and can be brought to compliance by the facility's strict adherence to the established policies and procedures outlined in the *Inmate Medical Services Policies and Procedures*, contract, and the standard nursing and physician practice.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation during this audit. Should you have any questions or concerns, you may contact Donna Heisser, Health Program Manager II (HPM II), Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services, CCHCS, at (916) 691-4849 or via email at Donna.Heisser@cdcr.ca.gov.

Sincerely,
Don Meier, Deputy Director
Field Operations, Corrections Services
California Correctional Health Care Services

Enclosure

cc: Richard Kirkland, Chief Deputy Receiver, CCHCS
Diana Toche, Undersecretary, Health Care Services, California Department of Corrections and Rehabilitation (CDCR)
R. Steven Tharratt, M.D., M.P.V.M., F.A.C.P., Director, Health Care Operations, CCHCS
John Dovey, Director, Corrections Services, CCHCS
Kathleen Allison, Director, Division of Adult Institutions (DAI), CDCR
Roscoe L. Barrow, Chief Counsel, CCHCS
Ricki Barnett, M.D., Assistant Statewide Medical Executive and Deputy Director, Medical Services, CCHCS
Jeffrey Carrick, M.D., Deputy Medical Executive, Utilization Management, CCHCS
Cheryl Schutt, Statewide Chief Nurse Executive, Nursing Services, CCHCS
Jay Virbel, Associate Director, Female Offender Programs and Services/Special Housing, DAI, CDCR
Joseph W. Moss, Chief, Contract Beds Unit, California Out-of-State Correctional Facility (COCF), DAI, CDCR
Michael J. Williams, Chief Deputy Administrator, Contract Beds Unit, COCF, DAI, CDCR
Ted Kubicki, Chief Executive Officer, North Kern State Prison, CCHCS

Bruce Barnett, M.D., JD, MBA, CCHP, Chief Medical Consultant, Office of Legal Affairs, CCHCS

Ada Rivera, M.D., Chief Medical Officer, Geo Group, Inc.

Joseph Williams, Correctional Administrator, Field Operations, Corrections Services, CCHCS

Luzviminda Pareja, Nurse Consultant Program Review, Field Operations, Corrections Services, CCHCS

Linda Larabee, Manager, Division of Internal Oversight and Research, CDCR

Donna Heisser, HPM II, PPCMU, Field Operations, Corrections Services, CCHCS

Kanika Broussard, HPM I, PPCMU, Field Operations, Corrections Services, CCHCS

Susan Thomas, Health Program Specialist I, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

CENTRAL VALLEY MODIFIED COMMUNITY CORRECTIONAL FACILITY

January 11-12, 2016

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DATE OF REPORT

Revised May 10, 2016

INTRODUCTION

As a result of an increasing inmate population and a limited capacity to house inmates, the California Department of Corrections and Rehabilitation (CDCR) entered into contractual agreements with private prison vendors to house California inmates. Although these inmates are housed in a contracted facility, either in or out-of-state, the California Correctional Health Care Services (CCHCS) is responsible to ensure health care standards equivalent to California's regulations, CCHCS's policy and procedure, and court ordered mandates are provided.

As one of several means to ensure the prescribed health care standards are provided, CCHCS staff developed a tool to evaluate the effectiveness, efficiency and compliance of the health care processes implemented at each contracted facility to facilitate patient access to health care. This audit instrument is intended to measure the facility's compliance with various elements of patient access to health care and to assess the quality of health care services provided to the patient population housed in these facilities.

This report provides the findings associated with the onsite audit conducted between January 11 through 12, 2016 at Central Valley Modified Community Correctional Facility (CVMCCF), which is located in McFarland, California, in addition to the findings associated with the review of various documents and patient medical records for the audit review period of July through December 2015. At the time of the audit, CDCR's *Weekly Population Count*, dated January 15, 2015, indicated a budgeted bed capacity of 700 beds, of which 635 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

From January 11 through 12, 2016, the CCHCS audit team conducted an onsite health care monitoring audit at CVMCCF. The audit team consisted of the following personnel:

Bruce Barnett, Medical Doctor, JD, MBA, CCHP, Chief Medical Consultant
Patricia Matranga, Registered Nurse
Susan Thomas, Health Program Specialist I

The audit included two primary sections: a *quantitative* review of established performance measures and a *qualitative* review of health care staff performance and quality of care provided to the patient population at CVMCCF. The end product of the quantitative review is expressed as a compliance score, while the end product of clinical case reviews is a quality rating.

The CCHCS rates each of the operational areas based on case reviews conducted by CCHCS physicians and registered nurses, medical record reviews conducted by registered nurses, and onsite reviews conducted by CCHCS physician, registered nurse, and Health Program Specialist I auditors. The ratings

for every applicable indicator may be derived from the clinical case review results alone, the medical record and/or onsite audit results alone, or a combination of both of these information sources (as shown in the *Executive Summary Table* below).

Based on the quantitative reviews and clinical case reviews completed for the 16 operational areas/quality indicators during the audit, CVMCCF achieved an overall point value of **0.6** which resulted in an overall audit rating of **inadequate.**

The completed quantitative reviews, a summary of clinical case reviews with the quality ratings and a list of critical issues identified during the audit are attached for your review. The *Executive Summary Table* below lists all the quality indicators/components the audit team assessed during the audit and provides the facility's overall quality rating for each operational area.

Executive Summary Table

Operational Area/Quality Indicator	Case Review Rating	Quantitative Review Score	Quantitative Review Rating	Overall Indicator Rating	Points Scored
1. Administrative Operations	N/A	84.8%	Inadequate	Inadequate	0.0
2. Internal Monitoring & QM	N/A	77.7%	Inadequate	Inadequate	0.0
3. Licensing/Certification, Training & Staffing	N/A	82.1%	Inadequate	Inadequate	0.0
4. Access to Care	Inadequate	86.8%	Adequate	Inadequate	0.0
5. Chronic Care Management	Inadequate	81.4%	Inadequate	Inadequate	0.0
6. Community Hospital Discharge	Inadequate	66.7%	Inadequate	Inadequate	0.0
7. Diagnostic Services	Adequate	77.3%	Inadequate	Inadequate	0.0
8. Emergency Services	Proficient	N/A	N/A	Proficient	2.0
9. Health Appraisal/Health Care Transfer	Adequate	56.7%	Inadequate	Inadequate	0.0
10. Medication Management	Inadequate	98.1%	Proficient	Adequate	1.0
11. Observation Cells	N/A	N/A	N/A	N/A	N/A
12. Specialty Services	Inadequate	46.6%	Inadequate	Inadequate	0.0
13. Preventive Services	N/A	100%	Proficient	Proficient	2.0
14. Emergency Medical Response/Drills & Equipment	N/A	65.3%	Inadequate	Inadequate	0.0
15. Clinical Environment	N/A	92.2%	Proficient	Proficient	2.0
16. Quality of Nursing Performance	Adequate	N/A	N/A	Adequate	1.0
17. Quality of Provider Performance	Adequate	N/A	N/A	Adequate	1.0
				Average	0.6
				Overall Audit Rating	Inadequate

NOTE: For specific information regarding any non-compliance findings indicated in the tables above, please refer to the Identification of Critical Issues (located on page 11 of this report), or to the detailed audit findings by quality indicator (located on page 14) sections of this report.

BACKGROUND AND PROCESS CHANGES

In April of 2001, inmates, represented by the Prison Law Office, filed a class-action lawsuit, known as *Plata vs. Schwarzenegger*, alleging their constitutional rights had been violated as a result of the CDCR health care system's inability to properly care for and treat patients within its custody. In June of 2002, the parties entered into an agreement (Stipulation for Injunctive Relief) and CDCR agreed to implement comprehensive new health care policies and procedures at all institutions over the course of several years.

In October 2005 the Federal Court declared that California's health care delivery system was "broken beyond repair," and continued to violate inmates' constitutional rights. Thus, the court imposed a receivership to raise the delivery of health care in the prisons to a constitutionally adequate level. The court ordered the Receiver to manage CDCR's delivery of health care and restructure the existing day-to-day operations in order to develop a sustainable system that provides constitutionally adequate health care to inmates. The court's intent is to remove the receivership and return operational control to CDCR as soon as the health care delivery system is stable, sustainable and provides for constitutionally adequate levels of health care.

The *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* was developed by the CCHCS in an effort to evaluate the effectiveness, efficiency and compliance of the health care processes implemented at each contracted facility to facilitate patient access to health care. This audit instrument is intended to measure facility's compliance with various elements of patient access to health care, and also to identify areas of concern, if any, to be addressed by the facility.

The standards being audited within the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* are based upon relevant Department policies and court mandates, including, but not limited to, the following: *Inmate Medical Services Policies and Procedures* (IMSP&P), California Code of Regulations (CCR), Title 8 and Title 15; *Department Operations Manual*; court decisions and remedial plans in the *Plata* and *Armstrong* cases, and other relevant Department policies, guidelines, and standards or practices which the CCHCS has independently determined to be of value to health care delivery.

It should be noted that, subsequent to the previous audit, major revisions and updates have been made to the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* and assessment processes. These revisions are intended to (a) align with changes in policies which took place during the previous several years, (b) increase sample sizes where appropriate to obtain a "snapshot" that more accurately represents typical facility health care operations, and (c) to present the audit findings in the most fair and balanced format possible.

Several questions have been removed where clear policy support does not exist, or where related processes have changed making such questions immaterial to measuring quality of health care services provided to patients. A number of questions have also been added in order to separate multiple requirements previously measured by a single question, or to measure an area of health care services not previously audited.

Additionally, clinical case review section has been added to the audit process. This will help CCHCS to better assess and evaluate the timeliness and quality of care provided by nurses and physicians at the contract facilities. The ratings obtained from these reviews will be utilized to determine the facility's overall performance for all *medical quality indicators* section. The resulting quality ratings from the case reviews will be incorporated with the quantitative review ratings to arrive at the overall audit rating and will serve as the sole decisive factor for determining compliance for some of the operational areas whereas for some of the other operational areas, case review ratings will play a dominant role in determining the overall compliance.

The revisions to the instrument and the added case review processes will likely produce ratings that may appear inconsistent with previous ratings, and will require corrective action for areas not previously identified. Accordingly, prior audit scores should not be used as a baseline for current scores. If progress and improvement are to be measured, the best tools for doing so will be the resolution of the critical issues process, and the results of successive audits. In an effort to provide the contractors with ample time to become familiar with the new audit tool, a copy of the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* was provided for their perusal prior to the onsite audit. This transparency afforded each contract facility the opportunity to make the necessary adjustments within their existing processes to become familiar with the new criteria being used to evaluate their performance.

OBJECTIVES, SCOPE, AND METHODOLOGY

In designing *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide*, CCHCS reviewed the Office of the Inspector General's medical inspection program and the IMSP&P to develop a process to evaluate medical care delivery at all of the in-state modified community correctional facilities and California out-of-state correctional facilities. CCHCS also reviewed professional literature on correctional medical care, consulted with clinical experts, met with stakeholders from the court, the Receiver's office, and CDCR to discuss the nature and the scope of the audit program to determine its efficacy in evaluating health care delivery. With input from these stakeholders, CCHCS developed a health care monitoring program that evaluates medical care delivery 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.

The audit incorporates both *quantitative* and *qualitative* reviews.

Quantitative Review

The *quantitative* review uses a standardized audit instrument, which measures compliance against established standards at each facility. The audit instrument calculates an overall percentage score for each of the operational areas/components in the *Administrative Quality Indicators and Medical Quality Indicators* section as well as individual ratings for each chapter of the audit instrument. Additionally, a brief narrative is provided addressing each standard being measured which received less than a 100% compliance rating.

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 14 medical and 3 administrative indicators of health care to

measure. The medical components cover clinical categories directly relating to the health care provided to patients, whereas the administrative components address the organizational functions that support a health care delivery system.

The 14 medical program components are: *Access to Care, Chronic Care Management, Community Hospital Discharge, Diagnostic Services, Emergency Services, Health Appraisal/Health Care Transfer, Medication Management, Observation Cells, Specialty Services, Preventive Services, Emergency Medical Response/Drills and Equipment, Clinical Environment, Quality of Nursing Performance* and Quality of Provider Performance. The 3 administrative components are: *Administrative Operations, Internal Monitoring and Quality Management and Licensing/Certifications, Training and Staffing.*

Every question within the chapter for each program component is calculated as follows:

- Possible Score = the sum of all *Yes* and *No* answers
- Score Achieved = the sum of all *Yes* answers
- Compliance Score (Percentage) = Score Achieved/Possible Score

The compliance score for each question is expressed as a percentage rounded to the nearest tenth. For example, a question scored 13 'Yes', 3 'N/A', and 4 'No".
Compliance Score = 13 'Yes' / 17 (13 'Yes' + 4 'No') = .764 x 100 = 76.47 rounded up to 76.5%.

The chapter scores are calculated by taking the average of all the compliance scores for all applicable questions within that chapter. The outcome is expressed as a percentage rounded to the nearest tenth.

Although the resulting scores for all chapters in the quantitative review are expressed as percentages, the clinical case reviews are reported as quality ratings. In order to maintain uniformity while reporting ratings for all operational areas/components, the quantitative scores for all chapters in Sections I and II are converted into quality ratings which range from *proficient*, *adequate*, or *inadequate*. See Table below for the breakdown of percentages and its respective quality ratings.

Percentile Score	Associated Rating	Numerical Value
90.0% and above	Proficient	2
85.0% to 89.9%	Adequate	1
Less than 85.0%	Inadequate	0

For example, if the three chapters under Section 1 scored 75.0%, 92.0%, and 89.0%, based on the above criteria, the chapters would receive ratings as follows:

Chapter 1 – 75.0% = Inadequate
Chapter 2 – 92.0% = Proficient
Chapter 3 – 89.0% = Adequate

Similarly, all chapter scores for Section II are converted to quality ratings. The resultant ratings for each chapter are reported in the *Executive Summary Table* of the final audit report. It should be noted that the chapters and questions that are found not applicable to the facility being audited are excluded from these calculations.

Qualitative Review

The *qualitative* portion of the audit consists of case reviews conducted by CCHCS clinicians. The CCHCS clinicians include physicians and registered nurses. The clinicians evaluate areas of clinical access and the provision of clinically appropriate care which tends to defy numeric definition, but which nonetheless have a potentially significant impact on performance. The intention of utilizing the case reviews is to determine how the various medical system components inter-relate and respond to stress, exceptionally high utilization, or complexity.

This methodology is useful for identifying systemic areas of concern that may compel further investigation and quality improvement. Typically, individuals selected for the case review are those who have received multiple or complex services or have been identified with poorly controlled chronic conditions. The cases are analyzed for documentation related to chronic care, specialty care, diagnostic services, medication management and urgent/emergent encounters. The CCHCS clinicians review the documentation to ensure that the above mentioned services were provided to the patients in accordance with the standards and scope of practice and the IMSP&P guidelines.

The CCHCS physician and nurse case reviews are comprised of the following components:

1. *Nurse Case Review*
   The CCHCS registered nurses perform two types of case reviews:

   a. Detailed reviews - A retrospective review of ten selected patient health records is completed in order to evaluate the quality and timeliness of care provided by the facility's nursing staff during the audit review period. A majority of the patients selected for retrospective review are the ones with a high utilization of nursing services, as these patients are most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.

   b. Focused reviews – Five cases are selected from the audit review period of which three cases consist of patients who were transferred into the facility. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations and continuity of care. The remaining two cases selected for review are patients, who were transferred out of the facility with pending specialty or chronic care appointments. These cases are reviewed to ensure that transfer forms contain all necessary documentation.

2. *Physician Case Review*
   The CCHCS clinician completes a detailed retrospective review of 15 patient health records in order to evaluate the quality and timeliness of care provided to the patient population housed at that facility.

Overall Quality Indicator Rating

The overall quality of care provided in each health care operational area (or chapter) is determined by reviewing the rating obtained from clinical case reviews and the ratings obtained from quantitative review. The final outcome for each operational area is based on the critical nature of the deficiencies identified during the case reviews and the standards that were identified deficient in the quantitative

reviews. For all those chapters under the *Medical Quality Indicator* section, whose compliance is evaluated utilizing both quantitative and clinical case reviews, more weight is assigned to the rating results from the clinical case reviews, as it directly relates to the health care provided to patients. However, the overall quality rating for each operational area is not determined by clinical case reviews alone. This is determined on a case by case basis by evaluating the deficiencies identified and their direct impact on the overall health care delivery at the facility. The physician and nurse auditors discuss the ratings obtained as a result of their case reviews and ratings obtained from quantitative review to arrive at the overall rating for each operational area.

Based on the collective results of the case reviews and quantitative reviews, each quality indicator is rated as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*.

Overall Audit Rating

Once a consensus rating for applicable Quality Indicator is determined based on the input from all audit team members, each chapter/quality indicator is assigned a numerical value based on a threshold value range.

The overall rating for the audit is calculated by taking the sum of all quality rating points scored on each chapter and dividing by the total number of applicable chapters. The resultant numerical value is rounded to the nearest tenth and compared to the threshold value range. The final overall rating for the audit is reported as *proficient, adequate, or inadequate* based on where the resultant value falls among the threshold value ranges.

In order to provide a consistent means of determining the overall audit rating (e.g., *inadequate, adequate,* or *proficient*) threshold value ranges have been identified whereby these quality ratings can be applied consistently. These thresholds are constant, and do not change from audit to audit, or from facility to facility. These rating thresholds are established as follows:

- **Proficient** - Since the cut-off value for a proficient rating in the quantitative review is 90.0% and the highest available point value for quality rating is 2 , the threshold value range is calculated by multiplying the highest available points by 90.0%, which is: 2 X 90.0% = 1.8. This value is a *constant* and has been determined to be the minimum value required to achieve a rating of *proficient.* Therefore, any overall score/value of 1.8 or higher will be rated as *proficient*. This is designed to mirror the performance standard established in the quantitative review (i.e., 90% of the maximum available point value of 2).
- **Adequate** - A threshold value of 1.0 has been determined to be the minimum value required to achieve a quality rating of *adequate*. Therefore, any value falling between 1.0 and 1.7 will be rated as *adequate*.
- **Inadequate** - A threshold value falling between the range of 0.0 and 0.9 will be assigned a rating of *inadequate*.

Average Threshold Value Range	Rating
1.8 to 2.0	Proficient
1.0 to 1.7	Adequate
0.0 to 0.9	Inadequate

$$\text{Overall Audit Rating} = \frac{\textit{Sum of All Points Scored on Each Chapter}}{\textit{Total Number of Applicable Chapters}}$$

Scoring for Non-Applicable Questions and Double-Failures:

Questions that do not apply to the facility are noted as Not Applicable (N/A). For the purpose of chapter and section compliance calculations, N/A questions will have zero (0) points available. Where a single deviation from policy would result in multiple question failures (i.e., "double-failure"), the question most closely identifying the primary policy deviation will be scored zero (0) points, and any resultant failing questions will be noted as N/A.

Resolution of Critical Issues

Although the facility will not be required to submit a corrective action plan to PPCMU for review, the facility will be required to address and resolve all standards rated by the audit that have fallen below the 85.0% compliance or as otherwise specified in the methodology. The facility will also be expected to address and resolve any critical deficiencies identified during the clinical case reviews and any deficiencies identified via the observations/ inspections conducted during the onsite audit.

IDENTIFICATION OF CRITICAL ISSUES

The table below reflects all quantitative analysis standards in which the facility's compliance fell below acceptable compliance levels, based on the methodology previously described. The table also includes any *qualitative* critical issues or concerns identified by the audit team which rise to the level at which they have the potential to adversely affect access to health care services.

Critical Issues – Central Valley Modified Community Correctional Facility	
Question 1.2	The facility does not have local operating procedures or policies and procedures that are compliant with the IMSP&P.
Question 1.7	Signed Release of Information Forms were not contained in the electronic medical record for all patients whose names were on the Release of Information Log.
Question 2.4	The facility does not submit all monitoring logs by the required scheduled dates.
Question 2.5	The facility does not accurately document all the dates on the sick call monitoring log.
Question 2.6	The facility does not accurately document all the dates on the specialty care monitoring log.
Question 2.7	The facility does not accurately document all the dates on the hospital stay/emergency department monitoring log.
Question 2.9	The facility does not accurately document all the dates on the initial intake screening monitoring log.
Question 2.13	The facility does not process all health care appeals within the required time frame.
Question 3.3	The facility does not have documentation that all of the health care staff has received training on the facility's policies and procedures.
Question 3.9	The facility does not provide a complete peer review of the facility's provider within the required time frames.
Question 4.5	The facility does not consistently conduct a focused subjective/objective assessment based upon the patient's chief complaint.
Question 4.6	The facility does not consistently document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data.
Question 4.8	The facility does not consistently document that effective communication was established and that education was provided to the patient related to the treatment plan.
Question 5.1	The facility does not consistently complete the patient's chronic care follow-up visit as ordered by the primary care provider (PCP).
Question 6.3	The patient is not consistently being seen by the PCP for a follow-up appointment within five calendar days of return from the community hospital or the hub facility.
Question 7.1	The facility does not consistently complete the patient's diagnostic test(s) within the time frame specified by the primary care provider.
Question 7.2	The PCP does not consistently review, sign, and date all patients' diagnostic test report(s) within two business days of receipt of results.

Question 7.3	The facility does not consistently give the patient written notification of his diagnostic test result(s) within two business days of facility's receipt of the results.
Question 7.4	The PCP does not consistently see the patient for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results.
Question 9.1	The facility is not consistently providing patients an initial health screening upon their arrival at the facility.
Question 9.2	The facility RN does not document an assessment of the patient if "YES" is answered to any of the medical problems on the *Initial Health Screening* form (CDCR 7277/7277A or similar form).
Question 9.6	The facility is not consistently scheduling the patient to see the facility's PCP within the timeframe ordered by the sending facility's PCP if the patient was enrolled in a chronic care program at a previous facility.
Question 9.7	The patient is not consistently seen at the receiving facility within the time frame specified by sending facility's provider if referred for a medical, dental or mental health appointment.
Question 9.8	The patient does not consistently receive a complete screening for the signs and symptoms of tuberculosis upon arrival at the facility.
Question 9.9	The patient does not consistently receive a complete health appraisal within seven calendar days of arrival at the facility.
Question 9.10	The patients do not consistently receive nurse administered medications administered without interruption and keep-on-person medications are not consistently received within one calendar day of arrival if they had an existing medication order upon arrival at the facility.
Question 9.11	The facility does not consistently document scheduled specialty services appointments that were not completed on a Health Care Transfer Information Form (CDCR 7371) or a similar form when the patient transfers out of the facility.
Question 12.3	The facility does not consistently document that upon the patient's return from the hub, a specialty consult appointment or community emergency department visit, a RN completed a face-to-face assessment prior to the patient's return to his assigned housing unit.
Question 12.4	The facility does not consistently document that upon a patient's return from the hub, a specialty consult appointment, or community emergency department visit, a registered nurse notified the primary care provider of any immediate orders or follow-up instructions provided by the hub, a specialty consultant, or emergency department physician.
Question 12.5	The PCP does not consistently review the specialty consultant's report, hub provider's report or the community emergency department provider's discharge summary and complete a follow-up appointment with the patient within the required time frame.
Question 14.4	The facility does not hold an Emergency Medical Response Review Committee a minimum of once per month.
Question 14.5	The facility failed to submit the required documentation with the Emergency Medical Response Review Committee (EMRRC) meeting minutes.

Question 14.7	The facility did not consistently document that the EMR bag was resupplied and resealed before the end of the shift if the emergency medical response and/or drill warranted an opening of the Emergency Medical Response Bag.
Question 14.9	The facility's EMR bag was not organized according to the audit checklist, and was missing a portable suction device.
Question 14.17	The facility does not have a portable suction device.
Question 15.4	Not all of the facility's health care staff adheres to universal hand hygiene precautions.
Question 15.6	Not all of the facility's health care staff disinfect the reusable non-invasive medical equipment between each patient use when they have been exposed to blood-borne pathogens or bodily fluids
Question 15.16	Not all clinic exam rooms have essential core medical equipment and supplies.

NOTE: A discussion of the facility's progress toward resolution of all critical issues identified during *previous* health care monitoring audits is included in the *Prior Critical Issue Resolution* portion of this report.

AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR

1. ADMINISTRATIVE OPERATIONS

This indicator determines whether the facility's policies and local operating procedures (LOP) are in compliance with IMSP&P guidelines and that contracts/agreements for bio-medical equipment maintenance and hazardous waste removal are current. This indicator also focuses on the facility's effectiveness in filing, storing, and retrieving medical records and medical-related information, as well as maintaining compliance with all Health Insurance Portability and Accountability Act requirements.

Case Review Rating: *Not Applicable*
Quantitative Review Score: *84.8%*

Overall Rating: *Inadequate*

This quality indicator is evaluated by CCHCS auditors entirely through the review of patient medical records and the facility's policies and local operating procedures. No clinical case reviews are conducted for this indicator and therefore, the overall rating is based on the results of the quantitative review.

The facility is required to have written local operating procedures (LOPs)/policies which are in compliance with IMSP&P guidelines. Four of the fifteen LOPs/policies used by the facility were in compliance with IMSP&P. Please see comments below regarding which policies were non-compliant.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Administrative Operations		Yes	No	Compliance
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	4	0	100%
1.2	Does the facility have written health care policies and/or procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	4	11	26.7%
1.3	Does the facility have current contracts/agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	3	0	100%
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	2	0	100%
1.5	Does the facility's health care staff access the California Department of Corrections and Rehabilitation patient's electronic medical record?	6	0	100%
1.6	Does the facility maintain a Release of Information log that contains all the required data fields?	1	0	100%

1.7	Are all patients' written requests for health care information documented on a CDCR Form 7385, *Authorization for Release of Information*, and scanned/filed into the patient's medical record?	8	4	66.7%
1.8	Are all written requests from third parties for release of patient medical information accompanied by a CDCR Form 7385, *Authorization for Release of Information*, from the patient and scanned/filed into the patient's medical record?	Not Applicable		
			Overall Quantitative Review Score:	**84.8%**

Comments:

1. Question 1.2 – The facility provided 4 local operating procedures (LOP) that were in compliance with IMSP&P, and 11 were not in compliance. The facility does not have a written LOP nor was there a corporate policy for Maintenance/Management of Patient Medical Records and Release of Health Information provided during the audit. The facility's LOPs for Chronic Care, Health Appraisal/Health Care Transfer Process, Access to Care (sick call), Specialty Services, American's With Disability Act, Staff Licensure and Training, and Infection Control Plan are not in compliance with IMSP&P. The Geo Corporate policies for Medication Management and Quality Management are also not in compliance with IMSP&P. The facility's LOPs for Chemical Agent/Use of Force, Emergency Medical Response and Drills, Aids to Impairment (Durable Medical Equipment), and Bloodborne Pathogen Exposure Control Plan are in compliance with IMSP&P. This equates to 26.7% compliance.
2. Question 1.7 – The logs contained twelve patient requests for copies of their medical records. Eight of the patient's medical records contained a signed medical record release. Four records did not contain a signed medical record release. This equates to 66.7% compliance.
3. Question 1.8 – Not applicable. The facility had 15 third party requests for release of information from the Department of State Hospitals (DSH). However, due to the nature of the request, the patient did not need to sign a release of information for DSH access to the records. There were no other third party requests for release of patient health care information received during the audit review period; therefore, this question could not be evaluated.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

This indicator focuses on whether the facility completes internal reviews and holds committee meetings in compliance with the policy. The facility's quality improvement processes are evaluated by reviewing minutes from Quality Management Committee (QMC) meetings to determine if the facility identifies opportunities for improvement, implements action plans to address the identified deficiencies identified and continuously monitors the quality of health care provided to patients. Also, CCHCS auditors evaluate whether the facility promptly processes patient medical appeals and appropriately addresses all appealed issues.

Case Review Rating: *Not Applicable*
Quantitative Review Score: *77.7%*

Overall Rating: *Inadequate*

In addition, the facilities are required to utilize monitoring logs (provided by PPCMU) to document and track all patient medical encounters such as initial intake, health appraisal, sick call, chronic care, emergency/hospital services and specialty care services. These logs are reviewed by PPCMU staff on a

monthly or a weekly basis to ensure accuracy, timely submission and whether the facility meets time frames specified in IMSP&P for each identified medical service. Rating of this quality indicator is based entirely on the quantitative review results from the review of patient medical records, review of QMC meeting minutes, review of patient health care appeals and facility's responses and review of the facility's monitoring logs.

The facility submitted the required monitoring logs in a timely manner 17.6% of the time. The facility failed to submit any monitoring logs during the month of October. The auditor's review of the five monitoring logs showed the facility does not accurately document dates on the logs. In addition, the facility is not using the correct version of the monitoring logs as supplied in July 2015. During the onsite audit, the HPS I spoke with the Health Services Administrator (HSA) and one of the registered nurses (RN) regarding the documentation deficiencies. Both stated they would work to improve their facility's accuracy when documenting on the monitoring logs.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Internal Monitoring & Quality Management		**Yes**	**No**	**Compliance**
2.1	Does the facility hold a Quality Management Committee a minimum of once per month?	6	0	100%
2.2	Does the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	6	0	100%
2.3	Does the Quality Management Committee's review process include monitoring of defined aspects of care?	6	0	100%
2.4	Does the facility submit all monitoring logs (sick call, specialty care, hospital stay/emergency department, chronic care and initial intake screening) by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	9	42	17.6%
2.5	Are the dates documented on the sick call monitoring log accurate?	39	21	65.0%
2.6	Are the dates documented on the specialty care monitoring log accurate?	10	20	33.3%
2.7	Are the dates documented on the hospital stay/emergency department monitoring log accurate?	5	4	55.6%
2.8	Are the dates documented on the chronic care monitoring log accurate?	45	5	90.0%
2.9	Are the dates documented on the initial intake screening monitoring log accurate?	19	10	65.5%
2.10	Are the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* readily available to patients in all housing units?	8	0	100%
2.11	Are patients able to submit the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* on a daily basis in all housing units?	8	0	100%
2.12	Does the facility maintain a CCHCS Health Care Appeals log and does the log contain all the required information?	1	0	100%

2.13	Are the first level health care appeals being processed within specified time frames?	10	2	83.3%
			Overall Quantitative Review Score:	**77.7%**

Comments:

1. Question 2.4 – The facility submitted 9 of the 51 required logs on time. The weekly logs were submitted on time 2 out of 13 weeks. The monthly chronic care log was submitted on time twice during the six month period and the monthly initial intake screening log was submitted on time once during the six month period. This equates to 17.6% compliance.

Type of Monitoring Log	Required Frequency of Submission	Number of Required Submissions for the Audit Review Period	Number of Timely Submissions	Number of Late Submissions
Sick Call	weekly	13	2	11
Specialty Care	weekly	13	2	11
Hospital Stay/Emergency Department	weekly	13	2	11
Chronic Care	monthly	6	2	4
Initial Intake Screening	monthly	6	1	5
	Totals:	**51**	**9**	**42**

2. Question 2.5 – Out of 60 date entries reviewed on the sick call logs, 39 entries were accurate and 21 entries were inaccurate. The deficiencies in the logs included; The "Date Sick Call Request Reviewed" documented on the log did not match the date found on the progress note in the patient's medical record for the services. Progress notes were missing from the medical record so the date on the log could not be validated. There were several instances of incorrect CDCR numbers. This equates to 65.0% compliance.

3. Question 2.6 – Out of 30 date entries reviewed on the specialty care monitoring logs, 10 dates were accurate and 20 were inaccurate. The dates documented on the log for the "PCP Referral Date" did not align with dates found in the patient's medical record for the services rendered. In addition, the records did not have progress notes to confirm the date documented in the "Date of RN Assessment After Specialty Consult Appointment" field. This equates to 33.3% compliance.

4. Question 2.7 – Out of nine date entries reviewed on the hospital stay/emergency department monitoring logs, five dates were accurate and four were inaccurate. The dates documented on the log as the date the patient returned to the MCCF from the hub and the "Date of RN Assessment Upon Return" did not match the dates found in the medical record or there were no progress notes to indicate an assessment was completed. This equates to 55.6% compliance.

5. Question 2.8 – Out of 50 date entries reviewed on the chronic care monitoring logs, 45 dates entered were accurate and 5 were inaccurate. The electronic medical records did not consistently contain progress notes for the dates documented in the "Last Assessment Date" column on the log. This equates to 90.0% compliance.

6. Question 2.9 – Out of 29 date entries reviewed on the initial intake screening monitoring logs, 19 dates were accurate and 10 were inaccurate. The arrival dates documented on the monitoring log are not the dates the patients arrived at the facility. Numerous medical records did not contain the 7277, *Initial Health Screening* Form or similar form, therefore it could not determined that an initial health screening had been conducted. This equates to 65.5% compliance.

7. Question 2.13 – There were 12 first level health care appeals for the audit review period. The HPS I reviewed the appeal responses for 11 health care appeals submitted. Ten responses were completed within the required time frame. One was not completed within the specified time frame, and the copy of one was not received by the auditor. This equates to 83.3% compliance.

3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING

This indicator will determine whether the facility adequately manages its health care staffing resources by evaluating whether: job performance reviews are completed as required; professional licenses and/or certifications are current; and, training requirements are met. The CCHCS auditors will also determine whether clinical and custody staff are current with emergency response certifications and if the facility is meeting staffing requirements as specified in their contract. Additionally, CCHCS will review and determine whether the facility completes a timely peer review of its medical providers (physicians, nurse practitioners, physician assistants).

Case Review Rating: *Not Applicable*
Quantitative Review Score: *82.1%*

Overall Rating: *Inadequate*

This indicator is evaluated by CCHCS auditors entirely through the review of facility's documentation of health care staff licenses, medical emergency response certifications, health care staff training records, and staffing information. No clinical case reviews are conducted for this indicator and therefore, the overall rating is based on the results of the quantitative review.

While onsite during the Corrective Action Plan (CAP) Review on November 2, 2015, the HPS I notified the HSA of the requirement that a peer review was to be completed on the current primary care provider (PCP) and submitted to CCHCS/PPCMU. PPCMU received a document dated December 11, 2015, from the Chief Medical Officer (CMO) for Correct Care Solutions (CCS) certifying that a Peer Review was conducted on the PCP. However, the Peer Review supporting documentation was not submitted. Without the supporting documentation containing the findings of the sample charts, PPCMU cannot verify or confirm that any medical charts were reviewed. The CMO was notified of the requirement to submit the Peer Review supporting documentation on all future reviews.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Licensing/Certifications, Training, & Staffing		Yes	No	Compliance
3.1	Are all health care staff licenses current?	6	0	100%
3.2	Are health care and custody staff current with required medical emergency response certifications?	95	9	91.3%

3.3	Did all health care staff receive training on the facility's policies based on Inmate Medical Services Policies and Procedures requirements?	5	1	83.3%
3.4	Is there a centralized system for tracking licenses, certifications, and training for all health care staff?	2	0	100%
3.5	Does the facility have the required provider staffing complement per contractual requirement?	1	0	100%
3.6	Does the facility have the required nurse staffing complement per contractual requirement?	5	0	100%
3.7	Does the facility have the required clinical support staffing complement per contractual requirement? (COCF Only)?	Not Applicable		
3.8	Does the facility have the required management staffing complement per contractual requirement? (COCF Only)	Not Applicable		
3.9	Are the peer reviews of the facility's providers completed within the required time frames?	0	1	0.0%
			Overall Quantitative Review Score:	**82.1%**

Comments:

1. Question 3.2 – All six of the health care staff's emergency medical response certifications were current. However, out of the 98 custody staff's certifications, 9 were expired. This equates to 91.3% compliance. As the facility was found less than 100% compliant with this requirement, it is identified as a critical issue and will be evaluated during the subsequent audit.
2. Question 3.3 – Of the six health care staff employed at CVMCCF, there was documentation five of the staff had received training on the facility's health care policies. There was no documentation the medical records clerk had received training. This equates to 83.3% compliance.
3. Questions 3.7 and 3.8 – Not applicable. These questions pertain to the staffing in out-of-state correctional facilities only.
4. Question 3.9 – The CCS CMO submitted a signature page dated 12/11/15, for the peer review of the facility's PCP; however, he did not submit the supporting documentation of his findings for PPCMU's physician to review. Therefore due to the lack of submission of supporting documentation for the peer review, CCHCS cannot verify or confirm that any medical charts were reviewed. This equates to 0.0% compliance.

4. ACCESS TO CARE

This indicator evaluates the facility's ability to provide patient population with timely and adequate medical care. The areas of focus include but are not limited to nursing practice and documentation, timeliness of clinical appointments, acute and chronic care follow-ups, face-to-face nurse appointments, provider referrals from nursing lines, and timely triage of sick call requests submitted by patients. Additionally, the auditors perform onsite inspections of housing units and logbooks to determine if patients have a means to request medical services and that there is continuous availability of CDCR Forms 7362, *Health Care Services Request*.

Case Review Rating: *Inadequate*
Quantitative Review Score: *86.8%*

Overall Rating: *Inadequate*

The case review and quantitative review processes resulted in different findings. The case review received an *inadequate* rating while the quantitative review resulted in an overall compliance score of 86.8%, resulting in an *adequate* rating.

The CCHCS nursing staff completed a review of 30 medical records relating to Access to Care. Overall deficient findings were related to nursing staff's failure to: conduct a focused subjective/objective assessment based upon the patient's chief complaint, document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data, document that effective communication was established, and to document that education was provided to the patient related to the treatment plan.

While the quantitative finding for Access to Care was found to be adequate, due to the potential impact of the deficiencies identified during the case reviews below, the CCHCS clinicians rated this indicator *inadequate*.

Case Review Results

The CCHCS auditors reviewed a total of 54 encounters related to Access to Care and found 25 deficiencies, of which 14 were related to nursing and 11 to provider care. The nursing deficiencies identified were:

- Delay in reviewing the sick call request form (Cases 1, 6, and 10).
- Failure to perform adequate nursing assessment related to the patient's chief complaint (Cases 4 and 6).
- Inappropriate nursing diagnosis (Case 6).
- No nursing diagnosis documented (Case 1).

The physician deficiencies identified were:

- Repeated eye complaints without visual acuity exam (Case 15).
- Polypharmacy (the simultaneous use of multiple drugs to treat a single ailment or condition) (Case 1).
- No indication of patient education (Cases 3, 5, 9, 11, and 13).

The case review rating for this indicator was *inadequate*.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Access to Care		Yes	No	Compliance
4.1	Does the registered nurse review the CDCR Form 7362, *Health Care Services Request*, or similar form on the day it is received?	26	4	86.7%

4.2	Following the review of the CDCR Form 7362, or similar form, does the registered nurse complete a face-to-face evaluation of a patient within the specified time frame?	29	1	96.7%
4.3	Does the registered nurse document the patient's chief complaint in the patient's own words?	27	3	90.0%
4.4	Does the registered nurse document the face-to-face encounter in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format?	30	0	100%
4.5	Is the focused subjective/objective assessment conducted based upon the patient's chief complaint?	17	13	56.7%
4.6	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	13	17	43.3%
4.7	Does the registered nurse implement a plan based upon the documented subjective/objective assessment data that is within the nurse's scope of practice or supported by the nursing sick call protocols?	29	1	96.7%
4.8	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	20	10	66.7%
4.9	If the registered nurse determines a referral to the primary care provider is necessary, is the patient seen within the specified time frame?	24	2	92.3%
4.10	If the registered nurse determines the patient's health care needs are beyond the level of care available at the facility, does the nurse contact or refer the patient to the hub institution? (MCCF Only)	2	0	100%
4.11	If the patient presented to sick call three or more time for the same medical complaint, does the registered nurse refer the patient to the primary care provider?	3	0	100%
4.12	Does nursing staff conduct daily rounds in segregated housing units? (COCF only)	Not Applicable		
4.13	Does nursing staff conduct daily rounds in segregated housing units to collect CDCR Forms 7362, *Health Care Services Request*, or similar forms? (COCF only)	Not Applicable		
4.14	Are CDCR Forms 7362, *Health Care Services Request*, or similar forms readily accessible to patients in all housing units?	8	0	100%
4.15	Are patients in all housing units able to submit the CDCR Forms 7362, *Health Care Services Request*, or similar forms on a daily basis?	8	0	100%
			Overall Quantitative Review Score:	**86.8%**

Comments:

For questions 4.1 through 4.11, CCHCS nursing staff reviewed a random sample of 30 medical records of patients receiving sick call services for the audit review period of July through December 2015.

1. Question 4.1 – Twenty-six medical records contained documentation that the RN reviewed the CDCR Form 7362, *Health Care Services Request*, on the day it was received, and four records had documentation that the 7362 was not reviewed the same day it was received. This equates to 86.7% compliance.

2. Question 4.2 – Twenty-nine medical records contained documentation that following the review of the CDCR Form 7362, the RN completed a face-to-face (FTF) evaluation of patients within the specified time frame; one record had documentation the RN did not completed a FTF within the specified time frame. This equates to 96.7% compliance.

3. Question 4.3 – Twenty-seven medical records contained documentation that the RN documented the patient's chief complaint in the patient's own words; three records the RN failed to document the patient's chief complaint in his own words, in the subjective section of the progress note. This equates to 90.0% compliance.

4. Question 4.5 – Seventeen medical records contained documentation that the RN completed a focused subjective/objective assessment based upon the patient's chief complaint and 13 failed to have documentation that a focused subjective/objective assessment was completed. This equates to 56.7% compliance.
5. Question 4.6 – Thirteen medical records contained documentation that the RN documented a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data; 17 records did not reflect documentation of a nursing diagnosis. This equates to 43.3% compliance.
6. Question 4.7 – Twenty-nine medical records contained documentation that the RN implemented a plan based upon the documented subjective/objective assessment data that is within the nurse's scope of practice and/or supported by the nursing sick call protocols. In one of the records, the nurse failed to document a plan based upon the documented subjective/objective assessment data. This equates to 96.7% compliance.
7. Question 4.8 – Twenty medical records contained documentation reflecting the RN documented effective communication was established and that education was provided to the patient, relating to the treatment plan. Ten medical records failed to contain documentation reflecting that effective communication was established or that education was provided. This equates to 66.7% compliance.
8. Question 4.9 – Four medical records reviewed were not applicable to this question as they did not require a referral to the PCP. Of the remaining 26 records reviewed, 24 contained documentation that, if the RN determined a referral to the PCP was necessary, the patient was seen within the specified time frame. Two records had documentation that the patient was referred to the PCP, however, there was no documentation the PCP visit took place. This equates to 92.3% compliance.
9. Questions 4.12 and 4.13 – Not applicable. These questions pertain to the patient population housed in out-of-state correctional facilities only.

5. CHRONIC CARE MANAGEMENT

For this indicator, the CCHCS auditors evaluate the facility's ability to provide timely and adequate medical care to patients with chronic care conditions. These conditions affect (or have the potential to affect) a patient's functioning and long-term prognosis for more than six months.

Case Review Rating: *Inadequate*
Quantitative Review Score: *81.4%*

Overall Rating: *Inadequate*

The case review and quantitative review processes resulted in similar findings. The chart review deficient findings were related to patients not being seen for their chronic care follow-up appointments within the time frame specified by the PCP and nursing staff's failure to document refusals if a patient failed to pick up his medication refills.

Taking into account all the findings related to Chronic Care Management, CCHCS clinicians rated this indicator *inadequate*.

Case Review Results

The CCHCS auditors reviewed a total of 13 encounters related to Chronic Care and found six deficiencies of which one was related to nursing performance and five related to provider performance.

The nursing deficiency identified was:

- Blood pressure monitoring was not completed as frequently as ordered by PCP (Case 3).

The physician deficiencies identified was:

- No indication of patient education regarding weight loss, risks of taking non-steroidal anti-inflammatory meds (Cases 3, 11 and 13).
- Incomplete examination of diabetic patient, no skin examination completed (Case 3).
- Laboratory tests not ordered for patient at risk for Diabetes Mellitus, other metabolic abnormality, fatty liver, etc. (Case 13).

The case review rating for this indicator was *inadequate*.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Chronic Care Management		**Yes**	**No**	**Compliance**
5.1	Is the patient's chronic care follow-up visit completed as ordered?	20	10	66.7%
5.2	Are the patient's chronic care medications received by the patient without interruption within the required time frame?	25	1	96.2%
5.3	If a patient refuses his/her chronic care keep-on-person medications, is the refusal documented on the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form?	Not Applicable		
5.4	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient referred to a primary care provider?	Not Applicable		
5.5	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient seen by a primary care provider within seven calendar days of the referral?	Not Applicable		
5.6	If a patient does not show or refuses his/her insulin, is the patient referred to a primary care provider for medication non-compliance?	Not Applicable		
			Overall Quantitative Review Score:	**81.4%**

Comments:

CCHCS nursing staff reviewed a random sample of 30 medical records of patients receiving chronic care management services during the audit review period of July through December 2015.

1. Question 5.1 – Twenty medical records reviewed contained documentation that the patient's chronic care follow-up visit was completed as ordered. Ten of the thirty records failed to contain documentation the chronic care visits were completed as ordered. This equates to 66.7% compliance.
2. Question 5.2 – Four records reviewed were not applicable to this question as patients were not prescribed any medication for their chronic care condition. Of the remaining 26 patient medical records reviewed; 25 included documentation that the patients' chronic care medications were received by the patient without interruption, within the required time frame. One record was non-compliant as the there is no medical administration record (MAR) documenting the patient picked up his medication refills for July and August 2015. This equates to 96.2% compliance.
3. Question 5.3 – Not applicable. There were no instances of any patient refusing his chronic care keep-on-person medications during the medical record review for this audit period. Therefore this question could not be evaluated.
4. Questions 5.4 and 5.5 – Not applicable. There were no instances of any patient not showing or refusing the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week during the audit review period. Therefore these questions could not be evaluated.
5. Question 5.6 – Not applicable. Of the 30 medical records reviewed for chronic care services, none of the patients' were prescribed insulin for their chronic care condition. CVMCCF does not house patients who are insulin dependent. Therefore this question could not be evaluated.

6. COMMUNITY HOSPITAL DISCHARGE

This indicator evaluates the facility's ability to complete timely follow-up appointments on patients discharged from a community hospital admission. Some areas of focus are the nurse face-to-face evaluation of the patient upon the patient's return from a community hospital or hub institution, timely review of patient's discharge plans, and timely delivery of prescribed medications.

Case Review Rating: *Inadequate*
Quantitative Review Score: *66.7%*

Overall Rating: *Inadequate*

There was only one patient who was admitted into the hospital during the audit review period.

Both the quantitative findings and case review yielded similar findings and the CCHCS clinicians rated this indicator as *inadequate*.

Case Review Results

For the patient who was admitted into the hospital during the audit period, upon his return to the MCCF from the hub institution, the RN failed to complete an initial health screening or TB screening. The patient had been held at the hub institution for more than a month after being released from the community hospital and required an initial health screening and a screening for signs and symptoms of TB. The case review rating for this indicator was *inadequate*.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Community Hospital Discharge		**Yes**	**No**	**Compliance**
6.1	*For patients discharged from a community hospital or returned from the hub:* Does the registered nurse review the discharge plan upon patient's return?	1	0	100%
6.2	*For patients discharged from a community hospital or returned from the hub:* Does the registered nurse complete a face-to-face assessment prior to the patient being re-housed?	1	0	100%
6.3	*For patients discharged from a community hospital or returned from the hub:* Is the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	0	1	0.0%
6.4	*For patients discharged from a community hospital:* Are all prescribed medications administered/delivered to the patient per policy or as order by the primary care provider?	Not Applicable		
			Overall Quantitative Review Score:	**66.7%**

Comments:

1. Question 6.3 – The one patient who was admitted into a community hospital and returned to the MCCF did not have documentation within his medical record indicating that the PCP at the MCCF saw the patient for a follow-up appointment within 5 calendar days of his return from the CDCR hub institution. This equates to 0.0% compliance.
2. Question 6.4 – Not Applicable. The patient released from the hospital was not prescribed any medications.

7. DIAGNOSTIC SERVICES

For this indicator, the CCHCS auditors assess several types of diagnostic services such as radiology, laboratory, and pathology. The auditors review the patient medical records to determine whether radiology and laboratory services were timely provided, whether the primary care provider timely reviewed the results, and whether the results were communicated to the patient within the required time frame. The case reviews also take into account the appropriateness, accuracy, and quality of the diagnostic tests ordered and the clinical response to the results.

Case Review Rating: *Inadequate*
Quantitative Review Score: *77.3%*

Overall Rating: *Inadequate*

The case review and quantitative review processes both resulted in similar findings. The CCHCS clinicians rated this indicator as *inadequate*.

Case Review Results

The CCHCS auditors reviewed a total of nine encounters related to Diagnostic Services, seven of which were nursing encounters and two provider encounters. Of the four deficiencies identified within these nine encounters, all were related to nursing performance. In Cases 2, 3, and 6, there was no documentation that could be located in the patient's medical record indicating diagnostic services were completed as ordered by provider.

The case review rating for this indicator was *inadequate*.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Diagnostic Services		**Yes**	**No**	**Compliance**
7.1	Is the diagnostic test completed within the time frame specified by the primary care provider?	18	4	81.8%
7.2	Does the primary care provider review, sign, and date all patients' diagnostic test report(s) within two business days of receipt of results?	15	5	75.0%
7.3	Is the patient given written notification of the diagnostic test results within two business days of receipt of results?	14	6	70.0%
7.4	Is the patient seen by the primary care provider for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results?	14	3	82.4%
			Overall Quantitative Review Score:	**77.3%**

Comments:

CCHCS nursing staff reviewed a random sample of 22 medical records of patients receiving diagnostic services during the audit review period of July through December 2015.

1. Question 7.1 – Eighteen medical records contained documentation that the patient received the diagnostic test within the time frame specified by the PCP; four records did not contain documentation that the diagnostic services ordered were completed. This equates to 81.8% compliance.

2. Question 7.2 – Two medical records reviewed failed in question 7.1. Under the double-failure rule, the points for these two records have been removed from the total points available for this question. Of the remaining 20 records reviewed, 15 contained documentation that the PCP reviewed, signed, and dated the patient's diagnostic test report(s) within two business days of receipt of results and 5 did not contain documentation that the PCP reviewed and/or signed the results within the specified time frame. This equates to 75.0% compliance.

3. Question 7.3 – Two medical records reviewed failed in question 7.1. Under the double-failure rule, the points for these two records have been removed from the total points available for this question. Of the remaining 20 records reviewed, 14 contained documentation that the patient was given written

notification of the diagnostic test results within two business days of receipt of results; 6 did not have documentation that written notification was provided within the specified time frame. This equates to 70.0% compliance.

4. Question 7.4 – Five medical records reviewed were not applicable to this question. One medical record did not have a significantly abnormal test result, and four records failed question 7.1. Under the double-failure rule, the points for these five records have therefore been removed from the total points available for this question. The remaining 17 records were reviewed, 14 contained documentation the patient was seen by the PCP for clinically significant/abnormal diagnostic test results within 14 days of the PCP's review of the test result. Three records contained no documentation the patient was seen by the PCP within the specified time frame. This equates to 82.4% compliance.

8. EMERGENCY SERVICES

This indicator evaluates the emergency medical response system and the facility's ability to provide effective and timely emergency medical responses, assessment, treatment and transportation 24 hours per day. The CCHCS clinicians assess the timeliness and adequacy of the medical care provided based on the patient's emergency situation, clinical condition, and need for a higher level of care.

This quality indicator is evaluated by CCHCS clinicians entirely through the review of patient medical files and facility's documentation of emergency medical response process. No quantitative results are conducted for this indicator and therefore, the overall rating is based on the results of the clinical case reviews.

Case Review Rating: *Proficient*
Quantitative Review Score: *Not Applicable*

Overall Rating: *Proficient*

Case Review Results

The CCHCS auditors reviewed one case which contained one RN and one PCP encounter related to Emergency Services. The RN and PCP both responded to an emergency of a patient with chest pain. The patient was assessed and emergency medical services were called. The patient was transported to the emergency department for evaluation. The CCHCS auditors found the facility RN and PCP provided appropriate care during the emergency response. Based on their review of these encounters, the CCHCS auditors found the quality of physician and nursing care in emergency services at CVMCCF was *proficient*.

9. HEALTH APPRAISAL/HEALTH CARE TRANSFER

This indicator determines whether the facility adequately manages patients' medical needs and continuity of patient care during inter- and intra-facility transfers by reviewing the facility's ability to timely: perform initial health screenings, complete required health screening assessment documentation (including tuberculin screening tests), and deliver medications to patients received from another facility. Also, for those patients who transfer out of the facility, this indicator reviews the

facility's ability to document transfer information that includes pre-existing health conditions, pending specialty and chronic care appointments, medication transfer packages, and medication administration prior to transfer.

Case Review Rating: *Adequate*
Quantitative Review Score: 56.7%

Overall Rating: *Inadequate*

The case review and quantitative review processes resulted in different findings. The case review received an *adequate* rating while the quantitative review resulted in an overall score of 56.7% compliance, equating to an *inadequate* rating. Upon arrival to the facility, not all patients received an initial health screening or screening for signs and symptoms of TB. Patients are not consistently referred for their chronic care appointment within the specified time frame as ordered by the sending facility's PCP, nor did they consistently have their existing medication reordered without interruptions.

Taking into account all the findings related to Health Appraisal/Health Care Transfer, CCHCS clinicians rated this indicator *inadequate*.

Case Review Results

The CCHCS nurse auditor reviewed a total of 21 encounters related to Health Care Appraisal/Health Care Transfer services and found two nursing deficiencies. The nursing deficiencies identified were:

- TB screenings were not consistently completed (Case 7).
- The transfer summary was not signed by the receiving institution nurse (Case 10).

As these deficiencies were minor in nature and unlikely to contribute to patient harm, the case review resulted in an *adequate* rating for this indicator.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Health Appraisal/Health Care Transfer		**Yes**	**No**	**Compliance**
9.1	Does the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	14	7	66.7%
9.2	If "YES" is answered to any of the medical problems on the *Initial Health Screening* form (CDCR 7277/7277A or similar form), does the registered nurse document an assessment of the patient?	3	2	60.0%
9.3	If a patient presents with emergent or urgent symptoms during the initial health screening, does the registered nurse refer the patient to the appropriate provider?	Not Applicable		
9.4	If a patient is not enrolled in the chronic care program but during the initial health screening was identified as having a chronic disease/illness, does the	Not Applicable		

	registered nurse refer the patient to the primary care provider to be seen within the required time frame?			
9.5	If a patient was referred to an appropriate provider during the initial health screening, was the patient seen within the required time frame?	1	0	100%
9.6	If a patient was enrolled in a chronic care program at a previous facility, is the patient scheduled and seen by the receiving facility's primary care provider within the time frame ordered by the sending facility's chronic care provider?	2	2	50.0%
9.7	If a patient was referred by the sending facility's provider for a medical, dental, or a mental health appointment, is the patient seen within the time frame specified by the provider?	0	1	0.0%
9.8	Does the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	7	14	33.3%
9.9	Does the patient receive a complete health appraisal within seven calendar days of arrival?	15	6	71.4%
9.10	If a patient had an existing medication order upon arrival at the facility, were the nurse administered medications administered without interruption and keep-on-person medications received within one calendar day of arrival?	1	7	12.5%
9.11	When a patient transfers out of the facility, are the scheduled specialty services appointments that were not completed, documented on a Health Care Transfer Information Form (CDCR 7371) or a similar form?	11	4	73.3%
9.12	Does the Inter-Facility Transfer Envelope contain all the patient's medications, current Medication Administration Record and Medication Profile?	2	0	100.0%
			Overall Quantitative Review Score:	**56.7%**

Comments:

CCHCS nursing staff reviewed a random sample of 21 medical records of patients receiving health appraisal/health care transfer services during the audit review period of July through December 2015.

1. Question 9.1 – Fourteen medical records reviewed contained documentation that the patient received an initial health screening upon arrival at the receiving facility by licensed health care staff; seven records did not have the CDCR 7277, *Initial Health Screening Form*. This equates to 66.7% compliance.

2. Question 9.2 – Sixteen medical records reviewed were not applicable to this question as the patient did not answer "yes" to any of the questions on the CDCR Form 7277. Of the remaining five medical records reviewed, three records contained documentation that when "YES" was answered to any of the medical problems on the CDCR Form 7277, the RN documented an assessment of the patient; two were non-compliant as nursing staff failed to document an answer to a mental health question and a patient with latent TB did not have an assessment. This equates to 60.0% compliance.

3. Question 9.3 – Not applicable. None of the 21 medical records reviewed showed the patient presented with emergent or urgent symptoms during the initial health screening and therefore did not require the RN to refer the patient to the appropriate provider. Therefore, this question could not be evaluated.

4. Question 9.4 – Not applicable. Three of the medical records reviewed showed the patient was already enrolled in the chronic care program. There was no documentation contained in the remaining 18 medical records to show those patients were identified during the initial health screening as having a chronic disease/illness; thereby not requiring the RN to refer the patient to the PCP to be seen. Therefore, this question could not be evaluated.

5. Question 9.6 – Seventeen medical records were not applicable to this question as the patients were not enrolled in the chronic care program nor did they have future chronic care appointments scheduled. Of

the remaining four records reviewed, two contained documentation that the patient was enrolled in a chronic care program at a previous facility and were scheduled and seen by the receiving facility's PCP within the time frame ordered by the sending facility's chronic care provider; two records were found non-compliant. This equates to 50.0% compliance.

6. Question 9.7 – Twenty medical records reviewed were not applicable to this question as they were not referred by the sending facility's PCP for a medical, mental, or dental appointment. The one remaining record reviewed did not contain documentation that the patient was seen for an orthopedic appointment within the time frame specified by the sending facility's provider. This equates to 0.0% compliance.
7. Question 9.8 – Seven medical records reviewed contained documentation that the patient received a complete screening for the signs and symptoms of tuberculosis upon arrival at CVMCCF; fourteen medical records did not contain documentation the patient received the TB screening. This equates to 33.3% compliance.
8. Question 9.9 – Of the 21 medical records reviewed for the audit review period, thirteen medical records for the months of July through October 2015, were reviewed. Ten records contained documentation that the patient received a complete health appraisal (H&P) within seven calendar days of his arrival to CVMCCF; one appraisal was completed within fourteen days of arrival; however, the facility was given credit for this case as the facility had not received the updated audit tool until August 2015. Two records did not contain the history & physical document for review and auditors were unable to validate an H&P had been completed. For the remaining eight records for the months of November and December 2015, four records showed the patient received a complete H&P within seven calendar days of arrival and four were not completed within the specified seven day time frame. This equates to 71.4% compliance.
9. Question 9.10 – Thirteen medical records reviewed were not applicable to this question as the patients did not have an existing medication order at the time of their arrival. Of the remaining eight qualifying records reviewed, only one record contained the documentation that the patient who had an existing medication order upon arrival at the facility received his medications without interruption and/or received his keep-on-person medications one calendar day of arrival at CVMCCF; seven failed to receive their medications within the specified time frame. This equates to 12.5% compliance.
10. Question 9.11 – Fifteen medical records were reviewed for patients who transferred out of the facility within the audit review period. Eleven records contained documentation that when the patient transferred out of the facility and there were scheduled specialty services appointments that have not been accomplished, the appointment information was documented on a *Health Care Transfer Information* Form (CDCR 7371); four records did not have the 7371 form. This equates to 73.3% compliance.

10. MEDICATION MANAGEMENT

For this indicator, CCHCS clinicians assess the facility's process for medication management which includes timely filling of prescriptions, appropriate dispensing of medications, appropriate medication administration (evaluated by direct observation of pill calls), complete documentation of medications administered to patients, and appropriate maintenance of medication administration records. This indicator also factors in the appropriate storing and maintenance of refrigerated drugs and vaccines and narcotic medications.

Case Review Rating: *Inadequate*
Quantitative Review Score: *98.1%*

Overall Rating: *Inadequate*

The case review and quantitative review processes resulted in different findings. The case review received an *inadequate* rating while the quantitative review resulted in an overall score of 98.1% compliance, equating to a *proficient* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on patient's health care condition. Taking into account the findings of the quantitative and case review processes, CVMCCF received an overall rating of *inadequate* performance in *Medication Management* indicator.

Case Review Results

The CCHCS auditors reviewed a total of 68 encounters related to medication management and found 8 deficiencies. Seven deficiencies were related to nursing performance and one to provider performance. The deficiencies were such that the auditors were unable to validate in many instances that patients received their medication as ordered by the PCP. Medications which had been discontinued by the PCP were continuously given to the patient past the date stopped by the PCP. The nursing deficiencies identified were:

- No documentation on a Medication Administration Record (MAR) showing meds were administered (Cases 2 and 4).
- Medications were discontinued by PCP but continued to be given to the patient (Case 3).
- KOP medication was refilled late (Case 9).

The clinical deficiency identified was:

- No medical need for topical treatment of toe nail fungus (Case 13).

The CCHCS clinicians rated the case reviews for this indicator as inadequate.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Medication Management		**Yes**	**No**	**Compliance**
10.1	Does the prescribing primary care provider document that the patient was provided education on the newly prescribed medications?	16	2	88.9%
10.2	Is the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	17	1	94.4%
10.3	Does the nursing staff confirm the identity of a patient prior to the delivery and/or administration of medications?	1	0	100%
10.4	Does the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	1	0	100%
10.5	Does the medication nurse directly observe a patient taking direct observation therapy medication?	1	0	100%

10.6	Does the medication nurse document the administration of nurse administered/direct observation therapy medications on the Medication Administration Record once the medication is given to the patient?	1	0	100%
10.7	Are medication errors documented on the Medication Error Report form?	1	0	100%
10.8	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food and/or laboratory specimens?	1	0	100%
10.9	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	62	0	100%
10.10	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas?	Not Applicable		
10.11	Are the narcotics inventoried at the beginning and end of each shift by licensed health care staff?	Not Applicable		
10.12	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers and/or nitroglycerine tablets? (COCF only)	Not Applicable		
			Overall Quantitative Review Score:	**98.1%**

Comments:

For questions 10.1 and 10.2, CCHCS nursing staff reviewed a random sample of 18 medical records of patients receiving medication management services during the audit review period.

1. Question 10.1 – Sixteen medical records were reviewed that contained documentation of the PCP providing education on the newly prescribed medications to the patient; two medical records did not have documentation citing that the PCP provided education on newly prescribed medications. This equates to 88.9% compliance.
2. Question 10.2 – Seventeen medical records were reviewed containing documentation that the initial dose of the newly prescribed medication was administered to the patient as ordered by the provider; one medical record failed to contain required documentation that a newly prescribed medication was administered as ordered by the PCP. This equates to 94.4% compliance.
3. Questions 10.10 and 10.11 – Not applicable. CVMCCF does not store narcotic medications at the facility.
4. Question 10.12 – Not applicable. The Modified Community Correctional Facilities do not have an administrative segregation unit; therefore this question applies only to out-of-state correctional facilities.

11. OBSERVATION CELLS

Case Review Rating: *Not Applicable*
Quantitative Review Score: *Not Applicable*

Overall Rating: *Not Applicable*

This quality indicator applies only to California out-of-state correctional facilities. The CCHCS auditors examine whether the facility follows appropriate policies and procedures when admitting patients to onsite inpatient cells. All aspects of medical care related to patients housed in observations cells are assessed, including quality of provider and nursing care.

This quality indicator does not apply to CVMCCF as the facility does not have any inpatient cells onsite. Patients requiring admission to inpatient housing are transferred to the hub

institution.

12. SPECIALTY SERVICES

For this indicator, CCHCS clinicians determine whether patients are receiving approved specialty services timely, whether the provider reviews related specialty service reports timely and documents their follow-up action plan for the patient, and whether the results of the specialists' reports are communicated to the patients. For those patients who transferred from another facility, the auditors assess whether the approved or scheduled specialty service appointments are received/completed within the specified time frame.

Case Review Rating: *Inadequate*
Quantitative Review Score: 46.6%
Overall Rating: *Inadequate*

The case review and quantitative review processes resulted in similar findings. Both reviews resulted in an inadequate rating.

Case Review Results

The CCHCS auditors reviewed a total of 14 encounters related to Specialty Services and found 7 deficiencies. Three deficiencies were related to nursing performance and four were related to provider performance. The nursing deficiencies identified were:

- In Cases 3 and 8, the nursing staff failed to consistently note discharge instructions, orders from the specialty consultant, medication(s), or follow-up requirements upon the patient's return to the facility.

The provider deficiencies identified were:

- Failure of the PCP to refer patient for specialty appointment (Case 15).
- Inadequate follow-up (Cases 1, 13, 14, and 15).

The CCHCS clinicians rated the case reviews for this indicator as inadequate. Taking into account the findings of the quantitative and case review processes, CVMCCF's performance for Specialty Services was rated as *inadequate.*

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Specialty Services		**Yes**	**No**	**Compliance**
12.1	Is the primary care provider's request for specialty services approved or denied within the specified time frame? (COCF Only)	Not Applicable		

12.2	Is the patient seen by the specialist for a specialty services referral within the specified time frame? (COCF Only)	Not Applicable		
12.3	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	17	4	81.0%
12.4	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse notify the primary care provider of any immediate orders or follow-up instructions provided by the hub, a specialty consultant, or emergency department physician?	0	2	0.0%
12.5	Does the primary care provider review the specialty consultant's report, hub provider's report or the community emergency department provider's discharge summary and complete a follow-up appointment with the patient within the required time frame?	10	7	58.8%
	Overall Quantitative Review Score:			**46.6%**

Comments:

For questions 12.3 through 12.5, CCHCS nursing staff reviewed a random sample of 21 medical records of patients receiving specialty services during the audit review period of July through December 2015.

1. Questions 12.1 and 12.2 – Not applicable. These questions pertain to the out-of-state correctional facilities only and are not applicable to CVMCCF.
2. Question 12.3 – Twenty one medical records were reviewed and seventeen contained documentation that upon the patient's return from the hub institution, a specialty consult appointment, or community ED visit, a RN completed a face-to-face (FTF) assessment prior to the patient's return to his assigned housing unit; four did not contain documentation that the RN completed a FTF assessment upon the patient's return. This equates to 81.0% compliance.
3. Question 12.4 – Nineteen medical records reviewed were not applicable as there were no immediate orders or follow-up instructions for these patients. Of the two applicable records, one failed to contain documentation that the RN reviewed the specialty encounter and in the other case the record did not contain documentation that the RN notified the PCP of medication recommended by the specialist. This equates to 0.0% compliance.
4. Question 12.5 – Four medical records reviewed were for audiology and optometry appointments and did not require follow-up. Of the remaining 17 cases, 10 records contained documentation that the PCP reviewed the specialty consultant's report, hub provider's report or the community ED provider's discharge summary and completed a follow-up appointment with the patient within the required time frame. There was no documentation in seven records that the PCP completed a follow-up appointment with the patient within the required time frame. This equates to 58.8% compliance.

13. PREVENTIVE SERVICES

This indicator assesses whether the facility offers or provides various preventive medical services to patients meeting certain age and gender requirements. These include cancer screenings, tuberculosis evaluation, influenza and chronic care immunizations.

This quality indicator is evaluated by CCHCS auditors entirely through the review of patient medical records. No clinical case reviews are conducted for this indicator and therefore, the overall rating is based on the results of the quantitative review.

Case Review Rating: *Not Applicable*
Quantitative Review Score: *100%*

Overall Rating: *Proficient*

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Preventive Services		Yes	No	Compliance
13.1	*For patients prescribed anti-Tuberculosis medication(s):* Does the facility administer the medication(s) to the patient as prescribed?	3	0	100%
13.2	*For patients prescribed anti-Tuberculosis medication(s):* Does the nursing staff notify the primary care provider or a public health nurse when the patient misses or refuses anti-TB medication?	Not Applicable		
13.3	*For patients prescribed anti-Tuberculosis medication(s):* Does the facility monitor the patient monthly while he/she is on the medication(s)?	3	0	100%
13.4	Do patients receive a Tuberculin Skin Test annually?	Not Applicable		
13.5	Are the patients screened annually for signs and symptoms of tuberculosis?	Not Applicable		
13.6	*For all patients:* Were the patients offered an influenza vaccination for the most recent influenza season?	Not Applicable		
13.7	***For all patients 50 to 75 years of age:*** **Are the patients offered colorectal cancer screening?**	**Not Applicable**		
13.8	*For female patients 50 to 74 years of age:* Is the patient offered a mammography at least every two years?	Not Applicable		
13.9	*For female patients 21 to 65 years of age:* Is the patient offered a Papanicolaou test at least every three years?	Not Applicable		
	Overall Quantitative Review Score:			**100%**

Comments:

For questions 13.1 and 13.3, CCHCS nursing staff reviewed three medical records for patients who were prescribed anti-TB medication during the audit review period. For questions 13.6 and 13.7, a random sample of 20 medical records was reviewed of patients receiving preventative services during the audit review period.

1. Question 13.2 – Not applicable. Of the three patients prescribed anti-TB medication, the patients did not miss or refuse any doses of anti-TB medication during the audit review period. Therefore this question could not be evaluated,

2. Questions 13.4 through 13.5 – Not applicable. The audit for these questions is conducted only during the audit period when annual TB testing occurs. Annual TB testing did not occur during the current audit review period. Therefore these questions could not be evaluated,

3. Questions 13.6 and 13.7 – Not applicable. These questions are evaluated once a year during the audit conducted between July and December. Therefore, these questions were not evaluated for this audit time period.
4. Questions 13.8 and 13.9 – Not applicable. These questions pertain to the female patient population only. Therefore this question could not be evaluated.

14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT

For this indicator, the CCHCS clinicians review the facility's emergency medical response documentation to assess the response time frames of facility's health care staff during medical emergencies and/or drills. The CCHCS auditors also inspect emergency response bags and various medical equipment to ensure regular inventory and maintenance of equipment is occurring.

Case Review Rating: *Not Applicable*
Quantitative Review Score: 65.3%
Overall Rating: *Inadequate*

This indicator is evaluated by CCHCS nurses entirely through the review of emergency medical response documentation, inspection of emergency medical response bags and crash carts (COCF only), and inspection of medical equipment located in the clinics. No clinical case reviews are conducted for this indicator and therefore, the overall rating is based on the results of the quantitative review.

The facility received an *inadequate* rating with a score of 65.3% in the *Emergency Medical Response/Drills & Equipment* indicator. The facility's Emergency Medical Response Bag was out of compliance and the facility did not have a portable suction device. The nurse auditor discussed the requirements for the EMR bag and the HSA ordered a portable suction device while the auditors were onsite. Refer to the *Comments* section, following the table below, for additional information and details on the deficiencies identified during the quantitative review of this indicator.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Emergency Medical Response/Drills & Equipment		Yes	No	Compliance
14.1	Does the facility conduct emergency medical response drills quarterly on each shift when medical staff is present?	7	0	100%
14.2	Does a Basic Life Support certified health care staff respond without delay after emergency medical alarm is sounded during an emergency medical response (man-down) and/or drill?	7	0	100%
14.3	Does a registered nurse or a primary care provider respond within eight minutes after emergency medical alarm is sounded for an emergency medical response (man-down) and/or drill?	7	0	100%

14.4	Does the facility hold an Emergency Medical Response Review Committee a minimum of once per month?	2	4	33.3%
14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	0	6	0.0%
14.6	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	93	0	100%
14.7	If the emergency medical response and/or drill warrant an opening of the Emergency Medical Response Bag, is the bag re-supplied and re-sealed before the end of the shift?	1	1	50.0%
14.8	If the emergency medical response bag has not been used for emergency medical response and/or drill, is it being inventoried at least once a month?	6	0	100%
14.9	Does the facility's Emergency Medical Response Bag contain only the supplies identified on the Emergency Medical Response Bag Checklist in compliance with Inmate Medical Services Policies and Procedures requirements?	0	1	0.0%
14.10	Is the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	Not Applicable		
14.11	If the emergency medical response and/or drill warrant an opening and use of the medical emergency crash cart, is the crash cart re-supplied and re-sealed before the end of the shift? (COCF Only)	Not Applicable		
14.12	If the medical emergency crash cart has not been used for a medical emergency and/or drill, was it inventoried at least once a month? (COCF Only)	Not Applicable		
14.13	Does the facility's crash cart contain all the medications as required/approved per *Inmate Medical Services Policies and Procedures*? (COCF Only)	Not Applicable		
14.14	Does the facility's crash cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	Not Applicable		
14.15	Does the facility have a functional Automated External Defibrillator with electrode pads located in the medical clinic?	1	0	100%
14.16	Does the facility have a functional 12-lead electrocardiogram machine with electrode pads? (COCF Only)	1	0	100%
14.17	**Does the facility have a functional portable suction device?**	**0**	**1**	**0.0%**
14.18	Does the facility have a portable oxygen system that is operational ready?	1	0	100%
	Overall Quantitative Review Score:			**65.3%**

Comments:

1. Question 14.4 – The facility submitted documentation that they held an Emergency Medical Response Review Committee Meeting for August, September, October, November and December. There was no meeting minutes submitted for July. The Warden, or designee, and HSA are both required to sign the meeting minutes. The August, October, and November minutes were not signed by both the warden and HSA. This equates to 33.3% compliance.

2. Question 14.5 – The facility failed to submit the following required documentation along with the meeting minutes for all months: 1st Medical Responder Data Collection tool, Triage and Treatment Services Flow Sheet, Interdisciplinary Progress Note, Medical Report of Injury or Unusual Occurrence; if utilized, the Cardiopulmonary Resuscitation Record, or similar forms.

3. Question 14.7 – The facility opened the EMR bag during the July 4th and August 21st drills. There is documentation that the lock was changed on 8/21/15; however, there is no documentation of a lock change that covers the July 4th drill. This equates to 50.0% compliance.

4. Question 14.9 – The EMR bag was not organized according to the Emergency Medical Response Bag Checklist, the bag was missing a portable suction device. This equates to 0.0% compliance.

5. Questions 14.10 through 14.14 – Not applicable. These questions pertain to crash carts and Modified Community Correctional Facilities do not utilize crash carts.
6. Question 14.17 – The facility does not have a portable suction device. However, the facility has a suction device located in the clinic which is small enough to be portable, but requires an electrical outlet for power. This equates to 0.0% compliance.

15. CLINICAL ENVIRONMENT

This indicator measures the general operational aspects of the facility's clinic(s). CCHCS auditors, through staff interviews and onsite observations/inspections, determine whether health care management implements and maintains practices that promote infection control through general cleanliness, adequate hand hygiene protocols, and control of blood-borne pathogens and contaminated waste. Rating of this quality indicator is based entirely on the quantitative review results from the visual observations auditors make at the facility during their onsite visit, as well as review of various logs and documentation reflecting maintenance of clinical environment and equipment.

Case Review Rating: *Not Applicable*
Quantitative Review Score: *92.2%*

Overall Rating: *Proficient*

The facility received a *proficient* rating with a score of 92.2% in the Clinical Environment indicator. One exam room was missing lubricant jelly; however, the clinic had the lubricant jelly in stock and restocked the room while the auditors were onsite.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Clinical Environment		Yes	No	Compliance
15.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	Not Applicable		
15.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	Not Applicable		
15.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	1	0	100%
15.4	Does clinical health care staff adhere to universal hand hygiene precautions?	2	1	66.7%
15.5	Is personal protective equipment readily accessible for clinical staff use?	1	0	100%
15.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	2	1	66.7%
15.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	1	0	100%
15.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	31	0	100%

15.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	2	0	100%
15.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	2	0	100%
15.11	Are sharps/needles disposed of in a puncture resistant, leak-proof container that is closeable, locked, and labeled with a biohazard symbol?	1	0	100%
15.12	Does the facility store all sharps/needles in a secure location?	1	0	100%
15.13	Does the health care staff account for and reconcile all sharps at the beginning and end of each shift?	93	0	100%
15.14	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	1	0	100%
15.15	Is the facility's biomedical equipment serviced and calibrated annually?	5	0	100%
15.16	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	1	1	50.0%
15.17	Does the clinic visit location ensure the patient's visual and auditory privacy?	1	0	100%
			Overall Quantitative Review Score:	**92.2%**

Comments:

1. Question 15.1 – Not applicable. CVMCCF does not use reusable medical instruments. Therefore this question could not be evaluated.

1. Questions 15.2 – Not applicable. CVMCCF does not use utilize autoclave sterilization. Therefore this could not be evaluated.

2. Question 15.4 – CCHCS nurse auditor observed three nursing staff during patient encounters. Two of the nursing staff was observed to adhere to universal hand hygiene precautions and one RN was observed not following the universal hand hygiene precautions before and after a patient encounter. This equates to 66.7% compliance.

3. Question 15.6 – CCHCS nurse auditor observed three nursing staff providing patient care. Two of the nurses were observed cleaning reusable non-invasive medical equipment between each patient use. However, one nurse failed to wipe the blood pressure cuff between patients. This equates to 66.7% compliance.

4. Question 15.16 – During the onsite audit, the clinic was noted to contain all essential core medical equipment and supplies; however, one exam room was noted to be missing lubricating jelly. This equates to 50.0% compliance.

16. QUALITY OF NURSING PERFORMANCE

The goal of this indicator is to provide a qualitative evaluation of the overall quality of health care provided to the patients by the facility's nursing staff. Majority of the patients selected for retrospective chart review are the ones with high utilization of nursing services, as these patients are most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.

Case Review Results

The CCHCS nurse auditor reviewed 15 patient health records in which 142 encounters were reviewed. Based on this review, the quality of nursing performance at CVMCCF was rated *Adequate.* There were 7 cases (Cases, 5, 7, 11, 12, 13, 14, and 15) found to be proficient during the nursing case review and therefore are not documented below. However, the remaining 6 adequate and 2 inadequate cases were found to contain 25 deficiencies related to nursing performance. The nursing services that were found to be inadequate/deficient include:

Case Review Rating: *Adequate*
Quantitative Review Score: *Not Applicable*

Overall Rating: *Adequate*

- Delay in reviewing the sick call requests (Cases 1, 6, and 10).
- Inadequate nursing assessment related to the patient's complaint (Cases 4 and 6).
- Inappropriate nursing diagnosis (Case 6).
- No documentation of nursing diagnosis (Case 1).
- Incorrect Nursing Protocol used (Case 6).
- Laboratory results documentation not found in medical record (Cases 2, 3, and 6).
- Unable to locate MAR showing medications were given (Cases 2 and 4).
- Medications were discontinued by PCP but still given to patient (Cases 3 and 9).
- Failure to document review of discharge instructions, any orders, medication, or follow-up requirements upon patient's return to the facility (Cases 3 and 8).
- Medications were refilled late (Case 9).
- Nursing staff failed to communicate with the PCP or refer patient to the PCP for follow-up (Physician Case Review 14).
- Nursing failed to document a diagnosis and failed to document if a referral to PCP was made (Physician Case Review 14).

Case Number	*Deficiencies*
Case 1	**Adequate.** Twenty-two year old patient complaining of persistent abdominal pain and episodes of vomiting. He was transferred to the hospital and found to have ruptured appendicitis. There was a delay in nursing reviewing a sick call request form and no nursing diagnosis documented on two encounters. The PCP failed to consider appendicitis during two encounters and the patient received polypharmacy (the simultaneous use of multiple drugs to treat a single ailment or condition).
Case 2	**Adequate**. Forty-two year old patient with chronic diagnosis of hypertension. During case review, nurse auditor was unable to locate lab report for ordered tests and there was no documentation showing the ordered lab tests were done. No documentation on a MAR that medication was given to patient.
Case 3	**Inadequate**. Fifty-four year old patient with chronic diagnoses of hypertension and diabetes mellitus (DM). The auditor found medication had been discontinued by the PCP, but was given to patient for almost a month longer and the auditor was unable to find lab reports in the medical record for lab tests ordered in October 2015. Nursing staff failed to document review of discharge instructions, any orders, medication, or follow-up requirements upon patient's return to the facility.

Case 4	**Adequate**. Thirty-one year old patient who has chronic constipation and abdominal pain. Patient developed shingles during the audit review period. The nurse auditor was unable to locate a MAR for pain medication in the medical record and therefore cannot determine if patient received the medication. Nursing staff failed to properly address the patient's complaint of pain and failed to document pain level.
Case 6	**Inadequate**. Thirty-six year old patient with a history of right knee anterior cruciate ligament (ACL) reconstruction in 2012, hematuria, alcohol and marijuana use. Complained of fungal infection on his feet, repeated nausea, dizziness, and vomiting. The nurse auditor was unable to find documentation that nursing had performed an adequate nursing assessment related to the patient's complaint. No vital signs were taken and no subjective and objective nursing assessments documented. Nursing staff used an incorrect nursing protocol form. Nursing assessment or diagnosis was not properly documented. The sick call request form was reviewed one day late. Inappropriate nursing diagnosis given. The nurse auditor was unable to locate documentation showing that laboratory tests were completed as ordered, and a sick call request was reviewed late. Nursing documented an inadequate objective assessment and did not have focused assessment. Nursing staff documented an inappropriate nursing diagnosis.
Case 8	**Adequate**. Fifty-three year old patient with a chronic diagnosis of hypertension. While at CVMCCF he complained of severe back pain. Based on the PCP's notes and orders, the patient was transferred back to the facility from the hub institution; however, there were no nursing notes available indicating the transfer or any new instructions.
Case 9	**Adequate**. Sixty year old patient with chronic diagnosis of hypertension and hyperlipidemia. The patient received a refill of his medication late.
Case 10	**Adequate**. Fifty year old patient with chronic diagnoses of Gastroesophageal Reflux Disease (GERD), Herpes Zoster, Hepatitis C, Arthritis, and Plantar Fascitis. Nurse administering medication failed to sign the MAR. The patient's sick call request was reviewed late, and the nurse who completed the Initial Intake Screening failed to sign the Transfer Summary Form.

Following are some recommendations provided by CCHCS on how the nursing performance at CVMCCF may be improved:

- Consider implementing a process where nursing, providers, and custody meet at the beginning of the work day to discuss:
    - patients to be seen that day;
    - patients who were sent out or returned from a community hospital ED visit or hospitalization;
    - patients seen on an urgent basis in the last 24 hours;
    - patients non-compliant with medications or ordered treatments/therapies; and
    - new arrivals with chronic health conditions.
- Implement a process that ensures chronic care medications are ordered and received by the patient prior to the patient finishing the previous month's supply.
- Implement a process to ensure nursing documents the administration of all medications. This is to include the one time medications ordered by provider.

The facility management staff is expected to take immediate action to resolve the deficiencies identified above. The facility is strongly encouraged to implement oversight and monitoring strategies for the

clinical nurse supervisor to evaluate nursing performance in assigned clinical areas and quality of nursing documentation.

17. QUALITY OF PROVIDER PERFORMANCE

In this indicator, the CCHCS physicians provide a qualitative evaluation of the adequacy of provider care at the facility. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, nursing sick call, chronic care programs, specialty services, emergency services, and specialized medical housing.

Case Review Rating: *Adequate*
Quantitative Review Score: *Not Applicable*

Overall Rating: *Adequate*

Case Review Results

Based on the 15 in-depth case reviews completed by CCHCS clinician, the facility provider performance was rated *adequate*. The current PCP's provider performance was found to be adequate. Of the 45 clinical encounters reviewed during the 15 detailed case reviews conducted by the CCHCS physician, 5 cases were inadequate and 10 cases deemed adequate.

Primary care services are delivered by a single provider at CVMCCF. The physician auditor spent three hours in discussion with the facility's current PCP and observed his care for two patients undergoing intake examination. Patients appear to receive substantial care by RN providers who rely upon protocols. Medical care at CVMCCF was reviewed for the time period of July 1, 2015 through December 31, 2015 and did not appear to overall meet applicable standards of care. In addition, multiple deficiencies were also noted where overall care was nonetheless adequate. The physician findings in this report and recommendations are based upon the observations made in tour of facility, conversations with medical staff, interview with Men's Advisory Committee (MAC) inmates, and review of selected medical records.

The provider services that were found to be inadequate/deficient include:

- PCP failed to consider likely diagnosis (Case 1).
- Polypharmacy, inappropriate prescription of milk of magnesia and antibiotic (Case 1).
- Medication prescribed without clinical indication (Cases 2, 3, 5, and 13).
- Effective communication not established (Case 3).
- Lack of patient education (Cases 3, 5, 9, 11, and 13).
- Failure to refer for specialty services (Case 15).

Case Number	*Deficiencies*
Case 1	***Inadequate***. Twenty-three year old male with periumbilical pain with sudden onset. Treated as gastroenteritis initially, then Irritable Bowel Syndrome (IBS) or Urinary Tract Infection (UTI) without adequate examination or diagnosis. Obvious appendicitis diagnosis not considered. Sent to hospital with a ruptured appendix one week after initial presentation. Inappropriately prescribed milk of magnesia and the medication Cipro as UTI very unlikely in a 23-year old male. Physician failed to diagnose appendicitis with classic presentation. Nurse follow-up was

	inadequate as well.
Case 2	***Adequate.*** Forty-two year old patient seen for routine care for borderline elevation of blood pressure. Coronary risk 2% does not justify daily aspirin. On appropriate blood pressure medication, but no indication for aspirin therapy.
Case 3	***Inadequate.*** Fifty-three year old patient with diagnoses of DM and morbid obesity. Treated with the medication Allopurinol for gout attacks. Patient complains of shaking in knees and leg symptoms consistent with excess weight. The PCP failed to communicate weight loss is a priority. Vitamins prescribed with no indication. Patient wrongly informed that there are "no meds available for restless leg syndrome." Effective communication was not documented. Overall care is inadequate due to lack of attention to crucial obesity, lack of diagnosis and reasonable management of weight. No clear reason why the medication Metformin was not prescribed.
Case 5	***Inadequate.*** Fifty-two year old patient with Hepatitis C Virus and neck pain who requests a muscle relaxant. Patient prescribed the medication Baclofen despite normal examination without clinical indication. PCP failed to provide education to the patient regarding risks of taking Non-steroidal Anti-Inflammatory drugs (NSAIDS). No clear documentation for the reason for KOP ibuprofen. The prescription of a controlled substance which is widely abused and without clinical indication is below the applicable standard of care.
Case 9	***Adequate.*** Thirty-seven year-old obese patient complains of elbow pain and a possible bone spur. The PCP failed to address patient's obesity. Body Mass Index (BMI) is 32. Bone spur treatment not indicated by Title 15. Unnecessary surgery should be avoided. Subsequent treatment has been appropriately conservative.
Case 11	***Adequate.*** Forty-seven year old patient followed for pre-hypertension with a normal examination. Repeat blood pressure (BP) checks ordered to verify BP at target without medication. No documentation of patient education regarding diet, exercise, etc. Mild BP elevation appropriately monitored without meds. Chart documentation lacking, but care is overall adequate.
Case 13	***Inadequate.*** Forty-seven year old patient diagnosed with GERD and obesity. Treated for toenail onychomycosis (fungus). The PCP failed to address diet and weight loss with patient. Topical treatment prescribed even though there was no medical need for treatment of toenail fungus. The PCP failed to pay attention to the medically significant issue of BMI exceeding 30 along with GERD symptoms, and prescribed medication which is not medically necessary per Title 15. In addition, the PCP failed to look for metabolic disease associated with onychomycosis.
Case 14	***Inadequate.*** Twenty-three year old patient complained of headache to RN. Was told to see PCP for follow-up. Four months later patient is still complaining of headache and there is no documentation of a PCP visit in the patient's medical record. There is no documentation that nursing staff communicated with the PCP or referred the patient to the PCP for follow-up. Nursing failed to document a diagnosis and failed to document if a referral to PCP was made.
Case 15	***Inadequate.*** Fifty-five year old patient with redness in the right eye with a foreign body sensation. Patient diagnosed with Rosacea and prescribed the medication Doxycycline. Patient with repeated eye complaints was not given a Snellen eye chart test to document normal vision. Patient with repeated eye complaints was not referred by the PCP for a specialty referral for a slit lamp exam to rule out iritis. Documentation of persistent eye redness and pain for three months with no visual acuity test given and no specialty referral. Patient at risk for glaucoma. No intraocular pressure tested.

The CCHCS physician auditors recommended the following to improve provider services at CVMCCF:

- The PCP should confer regularly with the staff nurses to jointly review patients with significant complaints, chronic diseases, or unusual symptoms.
- Nurses should be encouraged to consult with PCP on any new patient complaint for which a diagnosis has not already been made. Patients with new onset of abdominal pain or headaches should not be treated by nurse without physician consultation.
- Pharmacological therapy should be provided in accord with Title 15, which calls for the provision of only those services (including prescribing of medication) that are medically necessary.
- PCP to review the chronic use of NSAIDs for non-debilitating pain where there is a greater risk of Gastro Intestinal ulcers than benefit.
- Abnormal findings of any sort should be documented, followed with focused examinations and diagnosed with treatment in accord with best practices.
- Recommendations for elective surgery need to be considered carefully in light of Title 15.
- Patient refusals should be witnessed with documentation that full disclosure was made as to the possible consequences of the refusal.

PRIOR CRITICAL ISSUE RESOLUTION

The audit from January 2015 resulted in the identification of 12 quantitative and 9 qualitative critical issues. On November 3, 2015, CCHCS auditors performed a Corrective Action Plan (CAP) Review where the previously identified critical issues were reviewed. At the time of the CAP Review, 13 of the 21 items were found to be resolved and 8 remained unresolved. During the current audit, auditors found two of the eight remaining issues resolved, two issues are no longer monitored by the PPCMU, and the remaining four were not resolved to within the established compliance threshold. Below is a discussion of each previous critical issue:

1. Question 5.1 – *CHRONIC CARE FOLLOW-UP VISITS ARE NOT CONSISTENTLY COMPLETED WITHIN THE 90-DAY OR LESS TIME FRAME, OR AS ORDERED BY THE PRIMARY CARE PROVIDER (PCP).*

Prior Compliance	Current Compliance	Status
60.0%	66.7%	**Unresolved**

TThis issue was initially identified during the January 2015 audit. Five patient medical files were reviewed for compliance during the CAP Review in November 2015 and three records were found compliant with this requirement, resulting in a 60.0% compliance rating. During the current audit, 30 records were reviewed and twenty were compliant, resulting in a 66.7% compliance rating. The facility has failed to meet the established standard of 85.0% compliance; therefore, this deficiency is considered unresolved and will continue to be monitored during subsequent audits.

2. Question 7.2 – *THE PCP DOES NOT CONSISTENTLY REVIEW, INITIAL, AND DATE ALL INMATE-PATIENT DIAGNOSTIC REPORTS WITHIN THE SPECIFIED TIME FRAME.*

Prior Compliance	Current Compliance	Status
80.0%	78.9%	**Unresolved**

This issue was initially identified during the July 2014 audit and persisted through January 2015 audit. Five inmate-patient medical files were reviewed during the CAP Review and four were found compliant with this requirement, resulting in an 80.0% compliance rating. During the current audit, 15 out of 19 records were compliant with this requirement, resulting in a 78.9% compliance rating. The facility has failed to meet the established standard of 85.0% compliance; therefore, this deficiency is considered unresolved and will continue to be monitored during subsequent audits. The facility's management team is strongly encouraged to take immediate action to address and resolve this critical issue as it has been outstanding for over 18 months.

3. Question 7.3 – *THE PCP DOES NOT SEE THE INMATE-PATIENT FOR A FOLLOW-UP VISIT FOR CLINICALLY SIGNIFICANT DIAGNOSTIC TEST RESULT CONSISTENTLY WITHIN THE SPECIFIED TIME FRAME.*

Prior Compliance	Current Compliance	Status
60.0%	80.0%	**Unresolved**

This issue was initially identified during the July 2014 audit and persisted through January 2015 audit. During the CAP Review in November 2015, five patient medical files were reviewed for

compliance and three records were found compliant with this requirement, resulting in a 60.0% compliance rating. The current medical record review found 12 out of 15 records contained documentation that the patient was seen for a follow-up visit with the PCP for clinically significant diagnostic test results within the specified time frame, resulting in 80.0% compliance rating. The facility has improved their compliance, however they are still below the established standard of 85.0%; therefore, this deficiency is considered unresolved and will continue to be monitored during subsequent audits. The facility's management team is strongly encouraged to take immediate action to address and resolve this critical issue as it has been outstanding for over 18 months.

4. Question 14.2 – *THE PCP DOES NOT CONSISTENTLY DOCUMENT THE INMATE-PATIENT EDUCATION FOR NEWLY PRESCRIBED MEDICATIONS.*

Prior Compliance	Current Compliance	Status
80.0%	88.9%	**Resolved**

This issue was initially identified during the July 2014 audit and persisted through January 2015 audit. Five medical records of inmate-patients who received medication(s) were reviewed during the CAP Review. Four of the medical records reviewed had documentation that the PCP documented providing education for newly prescribed medications, resulting in 80.0% compliance. During the current audit, 16 out of 18 medical records reviewed contained documentation that the PCP provided the patient education on newly prescribed medication. The findings show that CVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

5. Question 15.1 – *INMATE-PATIENTS ARE NOT CONSISTENTLY BEING SEEN WITHIN THE TIME FRAMES SET FORTH IN THE SICK CALL POLICY.*

This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audits.

6. Question 15.2 – *INMATE-PATIENTS ARE NOT CONSISTENTLY BEING SEEN WITHIN THE TIME FRAMES SET FORTH IN THE SPECIALTY CARE POLICY.*

This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audits.

7. Qualitative Action Item #7 – *THE INMATE-PATIENT IS NOT BEING SEEN WITHIN THE SPECIFIED TIME FRAMES WHEN REFERRED TO THE HUB OR MCCF PCP BY THE MCCF RN.*

Status
Resolved

Four out of five records reviewed during the CAP Review case was found to have documentation the patient was seen within the specified time frames when referred to the hub institution or MCCF PCP by the MCCF RN, resulting in 80.0% compliance. The medical record review for the current audit period showed that, 26 out of 28 patients referred to the MCCF PCP or the hub PCP, were seen within the specified time frame, resulting in 92.8% compliance. The findings

show that CVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

8. Qualitative Action Item #8 – *A PEER REVIEW OF THE PCP IS NOT CONDUCTED ANNUALLY.*

Status
Unresolved

During the CAP Review in November 2015, the HSA was informed that the facility has been delinquent in conducting peer reviews. A copy of the IMSP&P, Volume 3, *Quality Management*, Chapter 4B, *and Primary Care Provider Mentoring – Proctoring Program and Clinical Performance Appraisal Process Procedure* was provided to the HSA. The HPS I notified the HSA of the requirement that a 120 day peer review was to be completed on the current PCP and submitted to CCHCS/PPCMU by November 21, 2015. PPCMU received a document dated 12/11/15, from the Chief Medical Officer for Correct Care Solutions, certifying that a Peer Review was conducted on the PCP. However, the Peer Review supporting documentation was not submitted for PPCMU Physician review. Since there is no way to validate the records reviewed for the peer review, this item is considered to be unresolved.

NEW CRITICAL ISSUES

All newly identified "Critical Issues" have been addressed in the *Audit Findings – Detailed by Quality Indicator* section of the report.

CONCLUSION

The facility's audit revealed that CVMCCF is struggling to consistently provide adequate health care to California patients. Coordination of nursing and physician services can be improved. In a few cases, apparent lack of communication between the MD and RN increased the risk of adverse clinical outcomes. Regular meetings between the MD and RNs should help decrease the risk of adverse clinical outcomes.

During the current audit, auditors found only two of the six remaining critical issues from the November 2, 2015, CAP Review resolved. Out of the four unresolved critical issues mentioned above, two have been unresolved for over 18 months.

The current audit resulted in 38 additional critical issues. The root causes appear to be related to insufficient documentation and lack of staff training. The facility's management is expected to work diligently with staff to improve the failing health care services being provided to the CDCR patients housed at CVMCCF. Developing, implementing and training all staff on policies and/or procedures identified as deficient will help the facility in their efforts to attain at least 85.0% compliance in all areas of the audit instrument. There is an apparent lack of concern and motivation on the part of management and supervisor team to bring resolution to the long outstanding critical issues; this is further exasperated by the identification of 39 new critical issues during this audit period. The documented deficiencies within this audit are reason for great concern in the vendor's ability to provide

an adequate level of care to California patients being housed at this facility. While these critical issues are fixable and are within the management's scope of control to ensure compliance, there appears to be lack of urgency on the part of the management team.

During the exit conference, the audit team debriefed CVMCCF on the deficiencies identified in this report. The Warden and the HSA were very receptive to constructive feedback presented by the audit team and assured the audit team that the identified issues will be resolved expediently. The Warden and HSA assured the audit team that CVMCCF will work diligently and efficiently to resolve the concerns and deficiencies addressed in this report in order to adhere to contractual obligations and to meet the expectations and requirements set forth in the IMSP&P.

PATIENT INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the patient population, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. This is accomplished via interview of all the ADA patients housed at the facility, the Men's Advisory Council (MAC) executive body and a random sampling of patients housed in general population, the facility does not have an administrative segregation unit. The results of the interviews conducted at CVMCCF are summarized in the table below.

Please note that while this chapter is not rated, audit team members made every attempt to determine with surety whether any claim of a negative nature could be supported by material data or observation. The results are briefly discussed in the "comments" section below.

Patient Interviews (not rated)
1. Are you aware of the sick call process?
2. Do you know how to obtain a CDCR 7362 or sick call form?
3. Do you know how and where to submit a completed sick call form?
4. Is assistance available if you have difficulty completing the sick call form?
5. Are you aware of the health care appeal/grievance process?
6. Do you know how to obtain a CDCR 602 HC or health care grievance/appeal form?
7. Do you know how and where to submit a completed health care grievance/appeal form?
8. Is assistance available if you have difficulty completing the health care grievance/appeal form?
Questions 9 through 21 are only applicable to ADA patients.
9. Are you aware of your current disability/DPP status?
10. Are you receiving any type of accommodation based on your disability? (Like housing accommodation, medical appliance, etc.)
11. Are you aware of the process to request reasonable accommodation?
12. Do you know where to obtain a reasonable accommodation request form?
13. Did you receive reasonable accommodation in a timely manner?
14. Have you used the medical appliance repair program? If yes, how long did the repair take?
15. Were you provided interim accommodation until repair was completed?
16. Are you aware of the grievance/appeal process for a disability related issue?
17. Can you explain where to find help if you need assistance for obtaining or completing a form, (i.e., CDCR 602-HC Inmate/Parolee Health Care Appeal Form, CDCR 1824 Reasonable Modification or Accommodation Request Form, or similar forms)?
18. Have you submitted an ADA grievance/appeal? If yes, how long did the process take?
19. Do you know who your ADA coordinator is?
20. Do you have access to licensed health care staff to address any issues regarding your disability?
21. During the contact with medical staff, do they explain things to you in a way you understand and take time to answer any question you may have?

Comments:

Ten patients were interviewed by the CCHCS auditor for questions one through eight. At the time of the onsite audit, MCCF housed one Disability Placement Program (DPP) patient which participated in the interviews. In addition, three MAC members were interviewed. Below is a summary of the responses received during the interviews:

MAC Committee interview – During the interview with the MAC committee inmates, all three inmates reported that the patient population at CVMCCF is reticent to speak about any health care issues which would require them to go to the hub institution for treatment. The patients fear being sent to the hub and not returned to CVMCCF for an extended period of time, or possibly not returned to the hub at all. Further follow up on this issue was explored upon return to headquarters. An analysis of specialty referral cases from CVMCCF sent to the hub institution during the audit review period revealed that 67 out of 76 patients who were referred to the hub institution for specialty services were returned to CVMCCF the same day, three patients stayed for longer than one day, and six were permanently transferred to the hub institution. Less than 15% of the patients referred to the hub institution for specialty services were not returned to the MCCF the same day.

1. Regarding questions 1 through 4 – All patients were able to fully explain the facility's sick call process, describe where/how to obtain a sick call request form and where to place the form when it is completed. While none of the patients stated they required assistance completing the forms, they stated if a patient needed assistance filling out the sick call form they could ask a fellow inmate, custody or health care staff. None of the patients interviewed had any negative comments regarding the sick call or health services provided at CVMCCF.
2. Regarding questions 5 through 8 – Seven patients interviewed were able to fully explain the facility's Health Care Grievance/Appeal process, describe where/how to obtain a Grievance/Appeal (602-HC) form and where to place the form when it is completed. Three patients stated they were not familiar with the Health Care Grievance Appeal process. The auditor explained the process to each patient. All three patients were able to verbalize his understanding of the process. While none of the patients stated they required assistance completing the form 602-HC form, they stated they could ask a fellow inmate, custody or health care staff for assistance. The auditor explained the Health Care Grievance/Appeal process to the one patient who stated he was not aware of the process.
3. Regarding question 9 – The DPP patient interviewed was able to describe his documented qualifying disability.
4. Regarding question 10 –The DPP patient interviewed was able to describe his documented accommodations (hearing aid, hearing impaired vest) for his disability.
5. Regarding question 11 – The DPP patient interviewed was able to describe the process and identify the form used to request reasonable accommodation.
6. Regarding question 12 – The DPP patient interviewed reported he would request a reasonable accommodation form from the facility HSA or housing officer if needed. The auditor informed patient that he could also request a reasonable accommodation form from the facility's ADA coordinator or from any of the health care staff.
7. Regarding question 13 – The patient reported he had received his reasonable accommodation while previously housed in a prison in California. The patient indicated he had received reasonable accommodation in a timely manner at the current facility upon his arrival.

8. Regarding question 14 – The patient reported he has previously used the repair services at CVMCCF approximately a year ago. He reported it took a while for his hearing aid to be repaired, but reports he has had no problems getting hearing aid batteries when needed.
9. Regarding question 15 – The patient reported while his hearing aid was not working, he would wear the vest provided to hearing impaired patients.
10. Regarding question 16 – The patient was able to describe the process for filing a grievance/appeal for his disability related issue.
11. Regarding question 17 – The patient reported he did not require any assistance obtaining or completing a CDCR 602-HC Inmate/Parolee Health Care Appeal Form, CDCR 1824 Reasonable Modification or Accommodation Request Form, or similar form, but if needed, he could ask a fellow inmate or health care staff.
12. Regarding question 18 – The patient reported he has not submitted an ADA grievance/appeal in the past.
13. Regarding question 19 – The patient did not know the name of the ADA coordinator, but indicated he would speak with the facility HSA if he needed assistance for his disability. The auditor provided the name of the ADA coordinator to the patient.
14. Regarding question 20 – The patient stated he felt he has access to licensed health care staff to address any issues regarding his disability.
15. Regarding question 21 – The patient stated he felt that health care staff at CVMCCF take their time with him during his medical visits and they explain things in a way he understands. The patient reported he is very satisfied with the health care provided to them at CVMCCF.