November 1, 2018

Gerald Morris, Warden
Leah Mayer, Health Services Administrator
Central Valley Modified Community Correctional Facility
254 Taylor Ave
McFarland, CA 93250

Dear Warden Morris and Ms. Mayer,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite Private Prison Compliance and Health Care Monitoring Limited Review audit at Central Valley Modified Community Correctional Facility (CVMCCF) on August 14 and 15, 2018. The purpose of this audit was to examine the facility's progress in resolving inadequate components and critical issues identified during the April 2018 annual audit.

On October 15, 2018, a draft report was provided to allow you the opportunity to review and dispute any findings presented in the report. On October 26, 2018, you submitted a response accepting the findings.

Attached is the final limited review audit report. The scope of the limited review included a re-examination of two components, Component 2, *Internal Monitoring & Quality Management* and Component 6, *Emergency Services and Community Hospital Discharge*, and 20 critical issues. As a result of the audit, one component received a passing score and 14 critical issues were found resolved.

Component 2, *Internal Monitoring and Quality Management*, received an overall component score of 92.9%, which is an increase of 22.1 percentage points from the 70.8% compliance score received during the annual audit. Auditors found five of the seven critical issues previously identified for this component resolved, and identified one new critical issue.

Component 6, *Emergency Services and Community Hospital Discharge*, received an overall compliance score of 72.7%, which is a slight increase of 0.5 percentage points from the 72.2% received during the annual audit. Auditors found the facility was unable to resolve either of the two prior critical issues for this component, and identified one additional critical issue.

The critical issues from the remainder of the components totaled eleven of which auditors found nine were resolved. The two unresolved issues were unable to be rated due to an insufficient sample size. These will be evaluated during the next annual audit. The facility is commended for resolving all but four critical issues in total. The audit team is very encouraged by this success.

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 Anastasia Bartle, Program Manager, Private Prison Compliance and Monitoring Unit, Field Operations, Corrections Services, CCHCS, at (916) 691-4921 or via email at Anastasia.Bartle@cdcr.ca.gov.

Sincerely,

Joseph (Jason) Williams, Deputy Director
Field Operations, Corrections Services
California Correctional Health Care Services

cc: Vincent S. Cullen, Director, Corrections Services, CCHCS
Joseph W. Moss, Chief, Contract Beds Unit (CBU), California Out of State Correctional Facility (COCF), Division of Adult Institutions (DAI), California Department of Corrections and Rehabilitation (CDCR)
Edward Vasconcellos, Chief Deputy Warden, CBU, DAI, CDCR
Ted Kubicki, Chief Executive Officer, North Kern State Prison, CCHCS
Brian Coates, Associate Warden, CBU, COCF, DAI, CDCR
Zacarias Rubal, Captain, CBU, DAI, CDCR
Jay Powell, Correctional Administrator, Health Care Placement Oversight Program (HCPOP), PPCMU, Field Operations, Corrections Services, CCHCS
Joseph Edwards, Captain, HCPOP, PPCMU, Field Operations, Corrections Services, CCHCS
Elizabeth DeSilva, Captain (A), HCPOP, PPCMU, Field Operations, Corrections Services, CCHCS
Tiffany Thompson, RN, Western Region Operations Manager, Correct Care Solutions
Marcus Harris, Regional Health Services Manager, The GEO Group, Inc.
Anastasia Bartle, Staff Services Manager II, PPCMU, Field Operations, Corrections Services, CCHCS
Christopher Troughton, Health Program Manager I (A), PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

Limited Review

Central Valley Modified

Community Correctional Facility

August 14-15, 2018

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DATE OF REPORT

November 1, 2018

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 and monitor the delivery of health care services provided at the contracted facility through a standardized audit process. The process is divided into phases; a remote phase and an onsite phase. The remote phase consists of a review of various documents obtained from the facility including health records, monitoring logs, staffing rosters. The onsite phase involves staff and patient interviews and a tour of all health care service points within the facility.

In accordance with the Receiver's directive, staff from the Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services conduct an annual audit of each contracted facility located in and out-of-state using the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide*. Based upon the percentage of compliance achieved per component and the overall score, the facility may undergo a follow-up limited review or a complete re-audit scheduled six months after the date of the annual audit. This second audit evaluates all components rated Inadequate and the critical issues in order to gauge progress toward improving compliance.

EXECUTIVE SUMMARY

An annual health care monitoring audit was conducted at Central Valley Modified Community Correctional Facility (CVMCCF) on January 30 through February 1, 2018. The audit review period was September through December 2017. The patient population at the time of the January onsite audit was 689 and the facility's budgeted capacity was 700[1]. The facility received an overall compliance rating of *Adequate* (89.8%) based on the scores compiled from each of the 14 components. Two components received a rating of *Inadequate*, and 20 critical issues were identified. As a result of failing one or more components and an overall rating of *Adequate*, a limited review audit was scheduled six months after the annual audit.

The PPCMU audit team conducted a limited review audit at CVMCCF on August 14 and 15, 2018. The audit review period was March through June 2018. The patient population at the time of the onsite audit

[1] Data from CDCR's Weekly Population Count report, dated January 26, 2018.

was 689 and the facility's budgeted capacity was 700[2]. The audit team consisted of the following personnel:

L. Pareja, Nurse Consultant, Program Review
S. Thomas, Health Program Specialist
S. Carroll, Health Program Specialist

The scope of the limited review included re-examination of:

- Two components, inclusive of both clinical case review and quantitative review
  - Component 2, *Internal Monitoring & Quality Management*.
  - Component 6, *Emergency Services and Community Hospital Discharge*.
- Twenty critical issues identified during the January 2018.

As a result of the August Limited Review, the audit team found much improvement in Component 2, an increase of 22.1 percentage points, and little improvement in Component 6, an increase of 0.5 percentage points. A comparison of the component scores between the January and August 2018 audits is listed below.

Executive Summary Table

Component	Audit Date	Nurse Case Review	Provider Case Review	Quantitative Review	Overall Component	Overall Component Rating
2. Internal Monitoring & Quality Management	January 2018	N/A	N/A	70.8%	70.8%	Inadequate
	August 2018	N/A	N/A	92.9%	92.9%	Proficient
Percentage Point Change		N/A	N/A	+22.1	+22.1	
6. Emergency Services & Community Hospital Discharge	January 2018	100.0%	66.7%	50.0%	72.2%	Inadequate
	August 2018	76.5%	75.0%	66.7%	72.7%	Inadequate
Percentage Point Change		-23.5	+8.3	+16.7	+0.5	

[2] Data from CDCR's Weekly Population Count report, dated August 10, 2018.

In addition, the audit team found 14 of the 20 critical issues identified during the annual audit were successfully resolved as detailed below.

Component	Critical Issues	Resolved	Unresolved	New Critical Issues
1. Administrative Operations	1	1	0	0
2. Internal Monitoring & Quality Management	7	5	2	1
3. Licensing/Certifications, Training & Staffing	2†	1	1*	0
6. Emergency Services & Community Hospital Discharge	2	0	2	1
8. Medical/Medication Management	2	1	1**	0
10. Specialty Services	2	2	0	0
12. Emergency Medical Response/Drills & Equipment	3	3	0	0
13. Clinical Environment	1†	1	0	0
Totals:	**20**	**14**	**6**	**2**

† These are qualitative issues related to the component.

* Peer review was not due for completion during the limited review audit period, therefore this issue was not rated.

** Auditors were unable to identify a sufficient sample size; therefore, the issue was not rated.

IDENTIFICATION OF CRITICAL ISSUES

The table below lists the six unresolved critical issues from prior audits and two newly identified critical issues from the August Limited Review.

Critical Issues – Central Valley Modified Community Correctional Facility	
Question 2.6	The facility does not accurately document data on the Specialty Care Log. ***This is an unresolved critical issue from the July 2014 audit.***
Question 2.8	The facility does not accurately document data on the Chronic Care Monitoring Log. ***This is an unresolved critical issue from the January 2018 audit.***
Question 2.10	The facility did not have the CDCR Form 602 HC A (Rev. 12/17), *Health Care Grievance Attachment* readily available to patients in all housing units. ***This is a new critical issue.***
Question 6.1	The facility's Registered Nurses (RNs) did not consistently review the patient's discharge plan/instructions upon the patient's return from a community hospital discharge. ***This is an unresolved critical issue from the January 2018 audit.***
Question 6.3	Patients are not consistently seen by the primary care provider (PCP) for a follow-up appointment within the required timeframe when returning from a community hospital discharge. ***This is an unresolved critical issue from the January 2018 audit.***
Question 6.4	For patients discharged from the Community Hospital, who were prescribed medications, CVMCCF failed to administer/deliver medication to the patient per policy or as ordered by the primary care provider. ***This is a new critical issue.***
Question 8.5	The facility did not consistently monitor patients monthly while the patients were taking anti-Tuberculosis (TB) medication(s). ***This is an unresolved critical issue from the January 2018 audit.***
Qualitative Issue # 2	The facility did not submit the PCP's peer review timely. ***This is an unresolved critical issue from the January 2018 audit.***

The unresolved and newly identified critical issues identified above will be monitored for compliance during subsequent audits.

LIMITED REVIEW AUDIT FINDINGS – FULL COMPONENT

During the January 2018 annual audit, two components received an *Inadequate* overall component rating. Component 2, *Internal Monitoring and Quality Management,* received an overall component score of 70.8%, and Component 6, *Emergency Services and Community Hospital Discharge,* received an overall component score of 72.2%. Per the audit methodology contained in the *Private Prison Compliance and Health Care Monitoring Unit Instruction Guide (Revised November 2017)*, all sections of these components were reviewed during the August Limited Review. A discussion of the seven previously identified and one newly identified critical issues in Component 2, and the two previously identified and one newly identified critical issues in Component 6 are discussed below.

2 – INTERNAL MONITORING AND QUALITY MANAGEMENT

Case Review Score: *N/A*
Quantitative Review Score: *92.9%*

Overall Score: 92.9%

This component focuses on whether the facility completes internal reviews and holds committee meetings in compliance with the CCHCS policies. Auditors review the minutes from Quality Management Committee meetings to determine if the facility identifies opportunities for improvement; implements action plans to address the identified deficiencies; and continuously monitors the quality of health care provided to patients. Auditors review the monitoring logs utilized by the facility to document and track all patient medical encounters such as initial intake, health assessment, sick call, chronic care, emergency, and specialty care services. These logs are reviewed for accuracy and timely submission to CCHCS. Lastly, auditors evaluate whether the facility promptly processes and appropriately addresses health care grievances.

The clinical case reviews are not conducted for this component; therefore, the overall component score is based entirely on the results of the quantitative review.

Quantitative Review Results

During the annual audit, CVMCCF received an overall rating of *Inadequate (*70.8%) with seven critical issues identified. During the limited review, the facility received a rating of *Proficient* (92.9%), with two unresolved prior critical issues and one new critical issue identified. Five of the seven prior critical issues were found resolved. Of the 13 questions reviewed, 9 were rated *Proficient*, 1 was rated *Adequate*, and 3 were rated *Inadequate.* Discussion of this component's critical issues is documented below.

During the annual audit, the Quality Management Committee (QMC) (identified as Continuous Quality Improvement at CVMCCF) failed to document identified opportunities for improvement (Question 2.2). Specifically, the QMC meeting minutes for December 2017 did not document verification of the RN's license renewal. During the limited review, all four QMC meeting minutes included corrective action plans for identified opportunities for improvement, resulting in 100% compliance.

During the annual audit, CVMCCF was not consistently submitting all weekly and monthly monitoring logs timely (Question 2.4). Three weekly logs were submitted late 10 out of 17 weeks, and the two monthly

logs were submitted late 1 out of 4 weeks. During the limited review, CVMCCF submitted the three weekly logs on time for all 20 weeks, and the two monthly logs were again submitted late 1 out of the 4 weeks. During the annual audit, the facility received a score of 45.8% for this question. During the limited review, the facility received a score of 97.1%, an increase of 51.3 percentage points. This critical issue is now resolved.

The auditor's review of the health care monitoring logs during the annual audit revealed the facility was not accurately documenting data on the logs. The deficiencies identified on the Sick Call, Specialty Care, Hospital Stay/Emergency Department, and Chronic Care monitoring logs (Questions 2.5 through 2.8) resulted in four critical issues. As a result of the limited review, auditors found two critical issues were resolved (Questions 2.5 and 2.7) and two unresolved (Questions 2.6 and 2.8). See table below for specific details.

Type of Monitoring Log	**Annual Audit**	**Limited Review**	**+/-**
Sick Call (Question 2.5)	70.6%	88.9%	+18.3
Specialty Care (Question 2.6)	29.4%	76.9%	+47.5
Hospital Stay/Emergency Department (Question 2.7)	75.0%	100.0%	+25.0
Chronic Care (Question 2.8)	65.0%	70.0%	+0.5

The monitoring logs for Specialty Care and Chronic Care received for the audit review period continued to contain inaccurate data; such as misspelled names, incorrect dates, or information inconsistent with what was found in the electronic health record.

During the annual audit the facility's health care grievance tracking log was not updated to reflect the current health care grievance regulations requirements (Question 2.12) resulting in a score of 0.0% compliance. The grievance log did not contain the correct information in the columns for Screening Disposition (Accepted/Rejected/Withdrawn) and Decision (Intervention/No-Intervention). The grievance log was also missing the columns for Date of RN Triage and the Grievance Type (Routine/Urgent/Emergent). During the limited review, the grievance tracking log was found to be updated with the correct information. The deficient columns were updated, and the missing columns were added, resolving this critical issue with a score of 100%.

The facility was found to be 100% compliant with regards to maintaining the CDCR Form 602-HC A *Health Care Grievance Attachment* in all eight housing units during the annual audit (Question 2.10). Although the facility achieved a Proficient rating for this question for the annual audit, this question was re-evaluated during the limited review. At that time, Dorms 1 and 3 located in Unit B did not have a supply of the CDCR Form 602-HC A readily available for patient use, resulting in a 75.0% compliance. The custody officers in these dorms immediately called for a supply to be brought to the dorms. The auditors re-checked the two dorms prior to the Exit Conference and saw both dorms had a sufficient supply of the CDCR Form 602 HC A. This new critical issue will be evaluated during subsequent audits to determine compliance.

6 – EMERGENCY SERVICES AND COMMUNITY HOSPITAL DISCHARGE

This component evaluates the facility's ability to complete timely follow-up appointments on patients discharged from a community hospital. 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 Score: *75.7%*
Quantitative Review Score: *66.7%*

Overall Score: 72.7%

The auditors evaluate the emergency medical response system and the facility's ability to provide effective and timely responses. The clinician auditors 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.

During the annual audit, the facility received an overall compliance rating of *Inadequate (*72.2%) with two critical issues identified. Results of the limited review showed CVMCCF achieved an overall compliance rating of *Inadequate* (72.7%*).* Both critical issues remain unresolved with one new critical issue identified. Specific findings for the nurse and physician case reviews, and the quantitative review are documented below.

Case Review Results

During the annual audit the facility received a case review compliance rating of *Adequate* (83.3%). The auditors reviewed seven patient encounters and found one deficiency. During the limited review, the auditors reviewed a total of 25 patient encounters and identified 6 deficiencies resulting in a rating of *Inadequate* (75.7%). This is a decline of 7.6 percentage points from the annual audit score.

Nurse Case Reviews

During the annual audit the NCPR auditor reviewed four nursing encounters and identified no deficiencies achieving a score of 100%. For the limited review, the NCPR auditor reviewed 17 nursing encounters and identified 4 deficiencies resulting in a score of 76.5%. This is a decrease of 23.5 percentage points. The specific deficiencies identified during the limited review are:

- **In Cases 16, 19, 20, and 25,** the patients were sent out to a community hospital. Upon their return from the hub institution following their discharge from a community emergency department or hospital, the RN completed a face-to-face assessment. However, in each case, the RN's progress notes did not clearly indicate the RN's review of the discharge instructions and/or any new orders.

Physician Case Reviews

During the annual audit, the physician auditor reviewed three provider encounters and identified one deficiency resulting in a score of 66.7%. For the limited review, the physician auditor reviewed eight provider encounters and identified two deficiencies resulting in a score of 75.0%. This is an increase of 8.3 percentage points. The specific deficiencies identified during limited review are:

- **In Case 2**, the patient was seen by the PCP 14 days after returning from the hub institution; nine days past the required time frame. The patient is required per policy to be seen by the PCP within five calendar days of returning to the facility.
- **In Case 9**, the patient received stitches at the hub institution for a laceration below the right eyebrow and returned to CVMCCF the same day. The patient should have been seen by the PCP within five calendar days of his return from the hub, however, the patient was not seen until seven days later.

Quantitative Review Results

During the annual audit, the facility received a quantitative compliance rating of *Inadequate* (50.0%) with two critical issues identified. During the limited review, all four questions for this component were re-evaluated resulting in a rating of *Inadequate* (66.7%). This is an increase of 16.7 percentage points from the annual audit. Of the four questions reviewed, one was rated Proficient and three were rated *Inadequate*. Both prior critical issues remain unresolved with one new critical issue identified. Discussion of this component's critical issues is documented below.

During the annual audit, the NCPR auditor identified nursing staff failed to consistently review the discharge plans of patients returning from a community hospital (Question 6.1). This resulted in a compliance score of 0.0%. During the limited review, the NCPR auditor reviewed six patient electronic health records and identified the nursing staff failed to review the discharge plans/instructions for three patients. This resulted in a compliance score of 50.0%, which is below the minimum compliance threshold. This remains a critical issue.

The NCPR auditor reviewed two electronic health records during the annual audit and identified a deficiency in one record. The health record did not have documentation the patient was seen by the PCP within the required time frame following the patient's return from a community hospital (Question 6.3). This resulted in a compliance score of 50.0%. The NCPR auditor reviewed six electronic health records during the limited review and identified a deficiency in two records. The NCPR auditor identified the patient's follow-up visit was not completed within five calendar days of return to the facility. This resulted in a compliance score of 66.7%, which is below the minimum compliance threshold. This remains a critical issue.

During the annual and limited review audits, the NCPR auditor reviewed the electronic health records of patients retuning from the community hospital to ensure medications prescribed upon discharge were administered/delivered to the patient as required (Question 6.4). During the annual audit review period, only two patients were discharged from a community hospital, both of which did not have any medications prescribed to them upon discharge. As a result, this question was not rated. During the limited review, only two patients were discharged from a community hospital. One record did not have documentation of CVMCCF administrating/delivering the medication(s) prescribed upon the patient's discharge from the community hospital. Nor did the record have documentation of the patient's refusal or failure to pick-up of the medication(s). This resulted in a compliance score of 50.0%, and the identification of a new critical issue.

LIMITED REVIEW AUDIT FINDINGS – CRITICAL ISSUES AUDIT

The annual audit conducted in January 2018 resulted in the identification of 20 critical issues, 17 quantitative and 3 qualitative. During the August 2018 Limited Review, auditors found 11 quantitative and 2 qualitative critical issues resolved, with the remaining 7 critical issues unresolved within acceptable standards. The facility's progress in resolving the critical issues associated with Components 2 and 6 are discussed in the preceding section, Limited Review Audit Findings – Full Component. The remainder discussed below.

1 – ADMINISTRATIVE OPERATIONS

During the annual audit, the facility achieved a quantitative rating of *Proficient* (95.0%*)* with one critical issue identified for this component.

1. The facilities LOPs/policies are not all in compliance with the IMSP&P. (Question 1.2)

Prior Compliance	Current Compliance	Status
60.0%	93.3%	**Resolved**

This critical issue was first identified during the January 2018 annual audit. At the time, a review of the facility's 15 LOPs showed 9 were compliant with IMSP&P, resulting in 60.0% compliance. During the limited review, the NCPR auditor reviewed the six LOPs previously identified as having deficiencies. Five LOPs were updated bringing them into compliance; however, the LOP for Medication Management remains non-compliant resulting in a score of 93.3%. This is an increase of 33.3 percentage points from the annual audit. This critical issue is resolved. The facilities resolution of this critical issue is discussed below.

- The *Licensure, Credentialing, and Training* LOP did not contain the documentation of the required time frames for new provider peer reviews to be completed. The auditor's assessment of this LOP during the limited review revealed this LOP was properly updated with the provider review time frames. (Reference: IMSP&P Volume 1, Chapter 32.2 New Medical Provider Onboarding Procedure)
- The *Infection Control and Blood Borne Pathogens Program* and *Tuberculosis Surveillance Program* LOP had a different facility's name in the header of the document. The auditor's assessment of this LOP during the limited review revealed this LOP was properly updated with the correct name in the header.
- The *Specialty Services* and *Access to Care* (Sick Call) LOP did not address the time frames required for the provider's assessment of the patient. The auditor's assessment of this LOP during the limited review revealed it was properly updated. The LOP was updated to include the time frames required for the provider's assessment of the patient upon return from a specialty appointment, higher level of care, and routine and urgent referrals from nursing staff. (Reference: IMSP&P, Volume 4, Chapter 8, *Outpatient - Specialty Services)*
- The facility submitted seven documents related to the *Medication Management* LOP during the annual audit. At the time the following requirements were missing from the documents deeming the LOP non-compliant with IMSP&P.

- New patients arriving at the facility without an adequate supply of their prescribed medication(s) must be referred to the PCP within eight hours of arrival. Assessment of the document received from CVMCCF during the limited review revealed this requirement is still missing. (Reference: IMSP&P, Volume 4, Chapter 2.2, *Reception Health Care Procedure)*
- To ensure medication continuity, nursing staff must obtain a renewed medication order(s) for patients transferring out of the facility with medication order(s) expiring within five days of transfer. Assessment of the document received from CVMCCF during the limited review revealed this requirement is still missing. (Reference: IMSP&P, Volume 4, Chapter 11.6, *Medication Continuity with Patient Movement: Transfer/Parole/Release Procedure*)
- The time frames for the availability and pick up of KOP medications (new or renewed) was not defined in the LOP. Assessment of the document received from CVMCCF during the limited review revealed this requirement is still missing. (Reference: IMSP&P, Volume 4, Chapter 11.2, *Medication Orders-Prescribing Procedure* and Chapter 11.4, *Medication Administration Procedure*)
    - Non-urgent new medication orders received by pharmacy on any business day shall be available to the patient no later than three business days later unless otherwise ordered (e.g., order specifies medication to start today).
    - Non-urgent renewed medication orders received by pharmacy on any business day shall be available to the patient no less than one business day prior to exhaustion of medication supply unless otherwise ordered (e.g., order specifies medication to start today).
    - In the event a patient does not pick up the KOP medication(s) within four business days of the medication becoming available, the licensed health care staff shall ensure the patient reports to the medication line to accept or refuse the medication.

While reviewing the LOPs provided by CVMCCF during the limited review, the NCPR auditor discovered additional deficiencies in four LOPs previously rated compliant. Additional deficiencies were also identified in the documents provided during the limited review for the Medication Management LOP. These deficiencies are not included in the scope of this limited review and are not part of the overall scoring for this question. The findings are described below.

- Emergency Medical Response - Two out of the three documents submitted for this LOP were identified to be non-compliant.
    - *Emergency Response Committee* (Policy number A-1200)
        - The effective date documented on the LOP is November 15, 2016; however, the facility did not submit documentation to show the LOP was reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*)

- The LOP does not list all the required forms to be completed when evaluating emergency medical responses and drills. (Reference: IMSP&P, Volume 4, Chapter 12.8, *Emergency Medical Response: Post Event Review Procedure*)
- The LOP does not specify the requirement for the Emergency Medical Response Review Committee (EMRRC) to review all reports of emergency medical responses and/or drills at the next scheduled EMRRC meeting following the incident or drill. The LOP currently states, "The institutions Emergency Response and Review Committee shall complete an initial review within thirty (30) days from the date of the incident." (Reference: IMSP&P, Volume 4, Chapter 12.8, *Emergency Medical Response: Post Event Review Procedure*)

- *Emergency Medical Response Training Drills* (Policy number A-1200b)
  - The effective date on the LOP is November 15, 2016; however, the facility did not submit documentation to show the LOP was reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*)

- Health Appraisal, Initial Health Screening, Health Care Transfer Process – All three documents submitted for this LOP were identified to be non-compliant.
  - *Initial Health Screening* (Policy number E-0200); *Medical Transfers* (Policy number E-0300); and *Chronic Care* (Policy number G-0100).
    - The effective date on all three LOPs was November 15, 2016; however, the facility did not provide documentation to show these LOPs were reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*)

- Medication Management – Four out of the seven documents submitted for this LOP were identified to be non-compliant.
  - *Formulary* (Policy number G-1000a)
    - The effective date documented on the LOP is November 15, 2016; however, the facility did not submit documentation to show the LOP was reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*)
  - *Medication Administration* (Policy number G-1000b).
    - The effective date documented on the LOP is November 15, 2016; however, the facility did not submit documentation to show the LOP was reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*)
    - The LOP did not state the prescriber shall provide and document effective communication explaining to the patient how to take newly prescribed medication(s). (Reference: IMSP&P, Volume 4, Chapter 11.2, *Medication Orders-Prescribing Procedure*)

        - The LOP does not document the process health care staff follow when the patient refuses to sign a refusal form. Specifically if the patient refuses to sign the CDCR Form 7225, *Refusal of Examination and-or Treatment*, two licensed health care staff shall sign. (Reference: IMSP&P, Volume 4, Chapter 11.5, *Medication Adherence Procedure*)

    - *Pharmacy Services* (Policy number G-1000c).
        - The effective date documented on the LOP is November 15, 2016; however, the facility did not submit documentation to show the LOP was reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*.)
        - The LOP does not discuss the process health care staff follow when the patient is a no show for a pill call. (Reference: IMSP&P, Volume 4, Chapter 11.5, *Medication Adherence Procedure*)
        - The LOP does not specify the process health care staff follow when a medication error is identified. (Reference: IMSP&P, Volume 3, Chapter 7.5, *Patient Safety Program Procedure: Institution Response to a Health Care Incident*)
    - *P and U Listed Pharmaceutical Waste* (Policy number G-1000g).
        - The effective date documented on the LOP is November 15, 2016; however, the facility did not submit documentation to show the LOP was reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*)

- Narcan Use and Storage – The facility included the language related to Narcan[3] (*naloxone*) use and storage in the policy for *Emergency Services* (Policy number A-1200a).
    - *Emergency Services* (Policy number A-1200a).
        - The effective date documented on the LOP is November 15, 2016; however, the facility did not submit documentation to show the LOP was reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*)
        - There should be a separate LOP for Narcan Use and Storage. (Reference: IMSP&P, Volume 4, Chapter 11.3, *Medication Storage and Accountability Procedure*; IMSP&P Volume 9, Chapter 5, *Emergency Drug Supplies Procedure*; CCHCS Memorandum #17-02, *Deployment and Use of Intranasal Naloxone within California Department of Corrections and Rehabilitation Adult Institutions*)

[3] Naloxone - medication administered via injection or nasally that blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. Naloxone is used to treat a narcotic overdose in an emergency situation.

- The LOP (A-1200a) does not include the requirement for the use of a designated Narcan Log. (Reference: CCHCS Memorandum #17-02, *Deployment and Use of Intranasal Naloxone within California Department of Corrections and Rehabilitation Adult Institutions*)

- Quality Management Program – The facility submitted one document related to this LOP.
  - *Continuous Quality Improvement/Performance Improvement and Risk Management Program Committee* (Policy number A-0600)
    - The effective date documented on the LOP is November 15, 2016; however, the facility did not submit documentation to show the LOP was reviewed annually. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*)

3 – LICENSING/CERTIFICATIONS, TRAINING & STAFFING

During the annual audit, the facility received a quantitative rating of *Proficient* (100%) with two qualitative critical issues identified for this component.

1. The facility's training log for health care staff was found to have dates that were incorrect. (Qualitative Issue #1)

Prior Compliance	Current Compliance	Status
N/A	N/A	**Resolved**

During the limited review, the auditors found staff accurately documented the dates for training completed during the audit review period on the facility's training logs. This critical issue is resolved.

2. The facility failed to submit the provider's peer review to the appropriate PPCMU representative. (Qualitative Issue #2)

Prior Compliance	Current Compliance	Status
N/A	N/A	**Not Rated**

During the annual audit, the auditor found the facility had completed the provider's peer review timely, however, it had not been submitted to PPCMU staff. This qualitative critical issue could not be rated during this limited review because the facility's next scheduled peer review was not due for submission. This critical issue remains unresolved and will be evaluated for compliance during the next scheduled annual audit.

8 - MEDICAL/MEDICATION MANAGEMENT

During the annual audit, the facility received a quantitative compliance rating of *Adequate* (85.2%) with two critical issues identified for this component.

1. The facility failed to consistently provide the patients with their chronic care medications within the required time frame. (Question 8.1)

Prior Compliance	Current Compliance	Status
31.3%	100.0%	**Resolved**

During the annual audit, the NCPR auditor's review of 16 electronic health records revealed five patients received their chronic care medications within the required time frame. During the limited review audit, the auditor's review of 16 patient health records showed all 16 patients were provided their chronic care medications within the required time frame, resulting in 100% compliance. This critical issue is resolved.

2. The facility failed to consistently monitor patients monthly while the patients were taking anti-tuberculosis medication(s). (Question 8.5)

Prior Compliance	Current Compliance	Status
0.0%	N/A	**Not Rated**

During the annual audit, there was one patient housed at CVMCCF during the audit review period who was prescribed anti-tuberculosis medication(s). The NCPR auditor's review of the patient's health record revealed the facility failed to consistently monitor the patients prescribed anti-tuberculosis medication(s) monthly. Since the facility did not have any patients on anti-tuberculosis medication(s) during the limited review audit period, this critical issue could not be evaluated for compliance. This critical issue remains unresolved and will be evaluated during subsequent audits.

10 - SPECIALTY SERVICES

During the annual audit, the facility received a quantitative component rating of *Inadequate* (57.5%) with two critical issues identified.

1. The facility RN failed to notify the PCP of any immediate medication or follow-up requirements ordered by the specialty consultant upon the patients return from their specialty services appointment. (Question 10.3)

Prior Compliance	Current Compliance	Status
0.0%	100.0%	**Resolved**

The NCPR auditor reviewed five health records for this question during the annual audit, and all five were found deficient. During the limited review, the auditor reviewed three health records

that met the criteria for this question. All three records contained documentation of the RN notifying the provider of the patient's immediate medication and follow-up instructions ordered by the specialty consultant, resulting in 100% compliance. This critical issue is resolved.

2. The facility's PCP did not consistently complete a follow-up appointment with the patient within the required time frame after their return from a specialty appointment. (Question 10.4)

Prior Compliance	Current Compliance	Status
40.0%	87.5%	**Resolved**

The second critical issue resulted due to the PCP not consistently completing follow-up appointments within the required time frame upon the patient's return from a specialty service appointment. The NCPR auditor reviewed ten electronic health records for this question during the annual audit and six were found deficient. During the limited review, the auditor's review of 16 electronic health records revealed 2 records were deficient, resulting in 87.5% compliance. This critical issue is resolved.

12 - EMERGENCY MEDICAL RESPONSE/DRILLS AND EQUIPMENT

During the annual audit, the facility received a quantitative rating of *Adequate* (84.4%) and three quantitative critical issues were identified.

1. The facility's emergency medical response (EMR) bag did not have all the required supplies as listed on the EMR bag checklist. (Question 12.8)

Prior Compliance	Current Compliance	Status
0.0%	100.0%	**Resolved**

The NCPR auditor inspected the facility's EMR bag during the onsite portion of the annual audit and found the bag was missing the oxygen tank listed on the checklist. During the onsite portion of the limited review, the NCPR auditor inspected the EMR bag and found the bag contained all the supplies listed on the checklist, resulting in 100% compliance. This critical issue is resolved.

2. Both of the facility's portable oxygen tanks were non-operational. (Question 12.14)

Prior Compliance	Current Compliance	Status
60.0%	100.0%	**Resolved**

During the onsite portion of the annual audit, the NCPR auditor found that the facility's two oxygen tanks were not operationally ready as they did not have a nasal cannula[4] attached. During the limited review, the NCPR auditor found both oxygen tanks were equipped with nasal cannulas and were operationally ready, resulting in 100% compliance. This critical issue is resolved.

[4] A flexible plastic apparatus (tubing) which utilizes two small tubes inserted into the nostrils for delivery of oxygen to a patient.

3. The facility did not account for the naloxone (Narcan) at the beginning and end of each shift. (Question 12.15)

Prior Compliance	Current Compliance	Status
0.0%	100.0%	**Resolved**

During the annual audit, the facility did not provide documentation they completed a reconciliation count of the medication naloxone at the beginning of each of the three shifts during the month reviewed (December 2017). During the limited review, the facility provided documentation of their reconciliation count of naloxone on all three shifts for the month reviewed (June 2018), resulting in 100% compliance. This critical issue is resolved.

13 - CLINICAL ENVIRONMENT

Although the facility received an overall compliance rating of *Proficient* (100%) for this component during the annual audit, one qualitative critical issue was identified.

1. The facility's RN staff did not consistently conduct face-to-face triage assessments and education to the patients in a location that ensures visual and auditory privacy. (Qualitative Issue #3)

Prior Compliance	Current Compliance	Status
N/A	N/A	**Resolved**

During the onsite portion of the annual audit, the NCPR auditor observed nursing staff completing their assessment of patients in the medical clinic's hallway rather than in the exam room. During the limited review, the NCPR auditor observed the facility nursing staff conducting assessments in a location that ensured visual and auditory privacy. This critical issue is resolved.

CONCLUSION

During the January 2018 Annual Audit, Components 2 and 6 failed to achieve an overall passing compliance score, and 20 critical issues were identified. As a result of the limited review audit, one component received a passing score and 14 critical issues were found resolved.

Component 2, *Internal Monitoring and Quality Management*, received an overall component score of 92.9%, which is an increase of 22.1 percentage points from the 70.8% compliance score received during the annual audit. Auditors found five of the seven critical issues previously identified for this component resolved, and identified one new critical issue. One of the unresolved critical issues, Question 2.6, was first identified during the July 2014 Annual Audit. The facility is not consistently documenting accurate data on the Specialty Care and Chronic Care Monitoring Logs. In addition, they did not have the CDCR Form 602-HC A readily available for patient use in the housing units.

Component 6, *Emergency Services and Community Hospital Discharge*, received an overall compliance score of 72.7% during the limited review, which is a slight increase of 0.5 percentage points from the 72.2% received during the annual audit. Auditors found the facility was unable to resolve the two prior critical issues for this component, and identified one additional critical issue. The facility is urged to maintain regular and timely communications with the Triage and Treatment Area providers at the CDCR hub institution, North Kern State Prison, and community hospital providers to ensure continuity of care. When patients return to the facility, staff are struggling with 1) timely receipt and review of the patient's discharge instructions, 2) timely administration of medications, and 3) timely provider follow-up appointments. During the onsite audit, the NCPR auditor recommended health care staff discuss all patients scheduled to be sent out to, and those that are scheduled to return from, the hub institution/community hospital daily. The facility management's expedited approach to resolve these critical issues is extremely critical to meet CCHCS's health care delivery standards.

The remainder of the critical issues previously identified in Components 1, 3, 8, 10, 12, and 13 were also re-evaluated. There were a total of 11 critical issues for these components. As a result of the limited review, nine were found resolved and two were unable to be rated. The facility is commended for resolving these critical issues. The audit team is very encouraged by their success.

At the conclusion of the audit, the auditors held an Exit Conference and discussed the preliminary limited review audit findings and recommendations with CVMCCF custody and health care management. The staff at CVMCCF were receptive to the findings, suggestions, and recommendations presented by the audit team, and expressed their dedication to implementing new processes to improve health care services, for California patients, in the areas that fell deficient during this audit.

APPENDIX A – QUANTITATIVE REVIEW RESULTS – Critical Issues Only

1. Administrative Operations		Audit Type	Yes	No	Compliance	Change
1.2	Does the facility have current and updated written health care policies and local operating procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	A	9	6	60.0%	+33.3
		LR	14	1	93.3%	

Comments:

1.2 The LOP for Medication Management reviewed during the limited review, was not in compliance with IMSP&P requirements.

2. Internal Monitoring & Quality Management		Audit Type	Yes	No	Compliance	Change
2.1	Did the facility hold a Quality Management Committee meeting a minimum of once per month?	A	4	0	100.0%	0.0
		LR	4	0	100.0%	
2.2	Did the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	A	2	2	50.0%	+50.0
		LR	4	0	100.0%	
2.3	Did the Quality Management Committee's review process include monitoring of defined aspects of care?	A	4	0	100.0%	0.0
		LR	4	0	100.0%	
2.4	Did the facility submit the required monitoring logs by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	A	27	32	45.8%	+51.3
		LR	66	2	97.1%	
2.5	Is data documented on the sick call monitoring log accurate?	A	12	5	70.6%	+18.3
		LR	16	2	88.9%	
2.6	Is data documented on the specialty care monitoring log accurate?	A	5	12	29.4%	+47.5
		LR	10	3	76.9%	
2.7	Is data documented on the hospital stay/emergency department monitoring log accurate?	A	3	1	75.0%	+25.0
		LR	7	0	100.0%	
2.8	Is data documented on the chronic care monitoring log accurate?	A	13	7	65.0%	+5.0
		LR	14	6	70.0%	
2.9	Is data documented on the initial intake screening monitoring log accurate?	A	17	3	85.0%	+15.0
		LR	20	0	100.0%	
2.10	Are the CDCR Forms 602-HC, *Health Care Grievance (Rev. 06/17) and 602 HC A, Health Care Grievance Attachment (Rev. 6/17),* readily available to patients in all housing units?	A	8	0	100.0%	-25.0
		LR	6	2	75.0%	
2.11	Are patients able to submit the CDCR Forms 602-HC, *Health Care Grievances,* on a daily basis in all housing units?	A	8	0	100.0%	0.0
		LR	8	0	100.0%	

2. Internal Monitoring & Quality Management		Audit Type	Yes	No	Compliance	Change
2.12	Does the facility maintain a Health Care Grievance log that contains all the required information?	A	0	1	0.0%	+100.0
		LR	1	0	100.0%	
2.13	Are institutional level health care grievances being processed within specified time frames?	A	1	0	100.0%	0.0
		LR	9	0	100.0%	
Overall Percentage Score and Change:				**January 2018**	**August 2018**	**+22.1**
				70.8%	**92.9%**	

Comments:

2.4 Of a total of 68 logs required to be submitted during the audit review period, 66 were received timely. All 64 weekly monitoring logs were received timely; two monthly logs were submitted late in June 2018.

2.5 Of the 18 entries evaluated, 2 were identified to have inaccurate spelling of names and both were missing documentation in their electronic health record.

2.6 Of the 13 entries evaluated 3 were identified to be non-compliant. The PCP assessment date documented on the log for one entry did not match the documentation in the health record. The second deficiency on the log was the missing PCP assessment date for another entry. The third was missing *The Request for Service* date for another entry on the log.

2.8 Six of the 20 entries evaluated were identified to be non-compliant. Two entries had the last names spelled incorrectly. Three additional entries listed chronic care conditions that did not match documentation found in the electronic health record. One entry documented an incorrect date in the *Next Scheduled Assessment Date* field on the log.

2.10 Two of the eight dorms (Unit B, Dorm 1 and 3) inspected during the onsite audit did not have the CDCR Form 602-HC A readily available for patient use.

6. Emergency Services & Community Hospital Discharge		Audit Type	Yes	No	Compliance	Change
6.1	*For patients discharged from a community hospital:* Did the registered nurse review the discharge plan/instructions upon patient's return?	A	0	2	0.0%	+50.0
		LR	3	3	50.0%	
6.2	*For patients discharged from a community hospital:* Did the RN complete a face-to-face assessment prior to the patient being re-housed?	A	2	0	100.0%	0.0
		LR	6	0	100.0%	
6.3	*For patients discharged from a community hospital:* Was the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	A	1	1	50.0%	+16.7
		LR	4	2	66.7%	
6.4	*For patients discharged from a community hospital:* Were all prescribed medications administered/delivered to the patient per policy or as ordered by the primary care provider?	A	0	0	N/A	N/A
		LR	1	1	50.0%	
Overall Percentage Score and Change:				**January 2018**	**August 2018**	**+16.7**
				50.0%	**66.7%**	

Comments:

6.1 Of the six patient health records reviewed, three were missing documentation stating an RN reviewed the patient's discharge plan or instructions upon their return to the facility from a community hospital.

6.3 Of the six patient health records reviewed, documentation in two records indicated the patients were not seen for a follow-up by the PCP within the five calendar day time frame, upon the patients' return from the hub.

6.4 Of the two patient health records reviewed, one record did not have documentation of the administration/delivery of medication(s) prescribed to the patient upon their release from the community hospital.

8. Medical/Medication Management		**Audit Type**	**Yes**	**No**	**Compliance**	**Change**
8.1	Were the patient's chronic care medications received by the patient within the required time frame?	A	5	11	31.3%	+68.7
		LR	16	0	100.0%	
8.5	*For patients prescribed anti-Tuberculosis medication(s):* Did the facility monitor the patient monthly while he/she is on the medication(s)?	A	0	1	0.0%	N/A
		LR	N/A	N/A	N/A	

Comments:

8.5 There were no patients prescribed anti-Tuberculosis medication(s) during the limited review audit period.

10. Specialty Services		**Audit Type**	**Yes**	**No**	**Compliance**	**Change**
10.3	Upon the patient's return from the specialty services appointment, did the registered nurse notify the primary care provider of any immediate medication or follow-up requirements provided by the specialty consultant?	A	0	5	0.0%	+100.0
		LR	3	0	100.0%	
10.4	Did the primary care provider review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patient within the required time frame?	A	4	6	40.0%	+47.5
		LR	14	2	87.5%	

Comments:

10.4 Of the 16 patient health records reviewed, two were missing documentation the PCP reviewed the specialty consultant's report/discharge summary and completed a follow-up appointment within the required time frame.

12. Emergency Medical Response/Drills & Equipment		Audit Type	Yes	No	Compliance	Change
12.8	Did the Emergency Medical Response Bag contain all the supplies identified on the facility's Emergency Medical Response Bag Checklist?	A	0	1	0.0%	+100.0
		LR	1	0	100.0%	
12.14	Does the facility have the emergency medical equipment that is functional and operationally ready?	A	3	2	60.0%	+40.0
		LR	6	0	100.0%	
12.15	Does the facility store naloxone (Narcan) in a secured area within each area of responsibility (medical clinics) and does the facility's health care staff account for the Narcan at the beginning and end of each shift?	A	0	93	0.0%	+100.0
		LR	90	0	100.0%	

Comments:

None.

APPENDIX B – 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 Americans with Disability Act (ADA) patients housed at the facility, the Inmate Advisory Council (IAC) executive body, and a random sample of patients housed in general population (GP). The results of the interviews conducted at CVMCCF are summarized in the table below.

Please note that while this section 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 Form 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 grievance process?
6. Do you know how to obtain a CDCR Form 602-HC, *Health Care Grievance*?
7. Do you know how and where to submit a completed health care grievance form?
8. Is assistance available if you have difficulty completing the health care grievance form?
Questions 9 through 21 are only applicable to ADA patients.
9. Are you aware of your current disability/Disability Placement Program (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 Form 602-HC, *Health Care Grievance*, CDCR Form 1824, Reasonable Modification or Accommodation Request, 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:

The auditors interviewed 12 patients during the onsite portion of the limited review. Three IAC members and an additional nine patients, two of which were designated as part of ADA/DPP. One patient spoke Spanish as his primary language and the facility provided an interpreter to assist with the interview.

Similar to the annual audit, the IAC members again reported patient frustration at not being able to participate in the over-the-counter (OTC) medication program wherein the patient is able to receive three free OTC medications per month. The auditors informed the patients of current efforts by headquarters staff to implement an OTC process at the MCCFs.

The IAC members also expressed concerns over their perception that patients at CVMCCF are not receiving dental services within the required time frame. The IAC members provided the names of two patients who felt they were not being seen timely. The auditors discussed the member's concerns with the Health Services Administrator (HSA) and upon return to the PPCMU headquarters, the auditors notified the Regional Program Support Team, Region III Dental Program of the member's concerns and provided the names and CDCR numbers of the two patients. The Regional Program Support Team, Region III Dental Program dentist reviewed both cases and identified the patients received dental services timely in the past and stated both patients had appointments pending prior to the end of the month (August 2018).

The two ADA patients at CVMCCF were interviewed. Both patients wore eyeglasses, and one was also hearing impaired and utilized hearing aids. One patient reported he had been waiting approximately six months for his new eyeglasses. After the interview, the auditors questioned the HSA about the status of the eyeglass order. The HSA reported she would contact the hub institution to check on the status of the order. The other patient stated his eyeglasses had been broken for two months and showed the auditors the temple[5] of his glasses which had been taped. When asked if he had submitted a request for the eyeglasses to be repaired, the patient reported he had not. The auditors encouraged the patient to submit a sick call slip to request his glasses be repaired and notified the HSA of the broken eyeglasses after the interview. This same patient was hearing impaired and he reported the facility has a good process in place to request and receive replacement batteries for his hearing aids when needed.

The auditors requested to interview eight patients randomly chosen from the facility's general population roster. One patient declined to be interviewed. The remaining seven patients were able to describe the process for requesting health care services. Two patients reported they have not had a need for health care services while at CVMCCF, and the remaining five said they were very happy with the services they received. Two patients reported they were not aware of the process to file a health care grievance. The auditors explained the process in detail and the patients verbalized their understanding. The remaining five were able to explain the health care grievance process correctly.

Overall, the patients interviewed during the onsite audit expressed they were satisfied with the health care services provided to them.

[5] Temple - Long arms on the sides of the frame that extend from the hinge and over the ears to keep the glasses on the wearer's face.

APPENDIX C – BACKGROUND AND AUDIT METHODOLOGY

1. 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 inmates 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.

In accordance with the Receiver's directive, the CCHCS Field Operations and Private Prison Compliance and Monitoring Unit's (PPCMU) management plan on conducting two rounds of audits in a calendar year for the private facilities Modified Community Correctional Facilities (MCCF) and the California out-of-state correctional facilities (COCF) currently in contract with CDCR. During the first six months of the calendar year, the PPCMU audit team will conduct an annual audit on all the facilities using the revised *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* (Revised November 2017) and Audit Tools. Based upon the overall audit rating received by the MCCF facility in their initial audit (*inadequate* or *adequate*), the facility will undergo a second round audit, which would be either a Full or a Limited Review. The COCF facilities will undergo two rounds of audits (full review or Limited Review) per calendar year regardless of the score received during the initial audit.

2. OBJECTIVES, SCOPE, AND METHODOLOGY

The *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* was developed by 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: *IMSP&P*, *California Code of Regulations*, 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.

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 chapters in the *Administrative* and *Medical Component* sections as well as individual ratings for each component of the audit instrument.

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 12 medical and three administrative components 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 12 medical program components are: *Access to Care, Diagnostic Services, Emergency Services and Community Hospital Discharge, Initial Health Assessment/Health Care Transfer, Medical/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 three 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 component scores are calculated by taking the average of all the compliance scores for all applicable questions within that component. The outcome is expressed as a percentage rounded to the nearest tenth. The qualitative rating for each component is described as *Proficient*, *Adequate*, or *Inadequate* according to whether standards were met more than 90%, more than 80% or less than 80%. See Table below for the breakdown of percentages and its respective quality ratings.

Percentile Score	Associated Rating
90.0% and above	Proficient
80.0% to 89.9%	Adequate
Less than 80.0%	Inadequate

Ratings for clinical case reviews in each applicable component and overall will be described similarly.

Qualitative Review

The *qualitative* portion of the audit consists of case reviews conducted by clinical auditors. The clinical auditors include physicians and registered nurses. The clinicians complete clinical case reviews in order to evaluate the quality and timeliness of care provided by the clinicians at the facilities. Individual patient cases are selected and followed utilizing an individual case review similar to well established methods utilized by the Joint Commission on Accreditation of Healthcare. 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 access to care, specialty care services, diagnostic services, medication management and urgent or emergent encounters. Once the required documentation is located in the record, the clinicians review the documentation to ensure that the abovementioned services were provided to the patients in accordance with the standards and scope of practice and the IMSP&P guidelines and to ensure complete and current documentation.

The clinical case reviews are comprised of the following components:

1. *Nurse Case Review*

   The NCPR auditors 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.
   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 and two cases consist of patients transferred out of the facility with pending medical, mental health, or dental appointments. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations, continuity of care, and completeness of the transfer forms.

2. *Physician Case Review*

   The physician auditor 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 Component Rating

The overall component rating is determined by reviewing the scores obtained from clinical case reviews and quantitative reviews. Scores for all components in the quantitative review are expressed as percentages. The clinical case review ratings are likewise reported in terms of the percentage of encounters that were rated as appropriate within the cases reviewed for each medical component. The final outcome for each component is expressed as a percentage and is calculated by averaging the quantitative and clinical case review scores received for that component.

For those components, where compliance is evaluated utilizing only one type of review (either clinical case or quantitative review), the overall component score will equate to the score attained in that specific

review. For all those chapters under the *Medical Component* section, where compliance is evaluated utilizing both quantitative and clinical case reviews, **double weight** will be assigned to the results from the clinical case reviews, as it directly relates to the health care provided to patients. For example, in Component 4, *Access to Care*, Facility A received 85.5% for clinical case review and 89.5% for quantitative review. The overall component score will be calculated as follows (85.5+85.5+89.5)/3 = 86.8%, equating to quality rating of *adequate*. *Note the double weight assigned to the case review score.*

Based on the derived percentage score, each quality component will be rated as either *proficient*, *adequate*, *inadequate*, or *not applicable*.

Overall Audit Rating

The overall rating for the audit is calculated by taking the percentage scores for all components (under both *Administrative* and *Medical* components) and dividing by the total number of applicable components.

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

The resultant percentage value is rounded to the nearest tenth and compared to the threshold value range (listed in Table below). The final overall rating for the audit is reported as *proficient, adequate, or inadequate* based on where the average percentage value falls among the threshold value ranges.

Average Threshold Value Range	Rating
90.0% - 100.0%	Proficient
80.0% - 89.9%	Adequate
0.0% to 79.9%	Inadequate

The compliance scores and ratings for each component are reported in the *Executive Summary table* of the final audit report.

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 component 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 the Private Prison Compliance and Monitoring Unit for review, the facility will be required to address and resolve all standards rated by the audit that have fallen below the 80.0% 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.