February 15, 2019

Paul Lozano, Chief
Shafter Modified Community Correctional Facility
1150 East Ash Avenue
Shafter, CA 93263

Dear Chief Lozano,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite Private Prison Compliance and Health Care Monitoring Limited Review audit at Shafter Modified Community Correctional Facility (SMCCF) on November 28, 2018. The purpose of this audit was to examine the facility's progress in resolving inadequate components and critical issues identified during the June 2018 annual audit.

On February 6, 2019, a draft report was provided to allow you the opportunity to review and dispute any findings presented in the report. The due date for SMCCF to submit a rebuttal to PPCMU was February 13, 2019. Since PPCMU did not receive a response by the due date, the draft report is considered final.

Attached is the final limited review audit report. The scope of the limited review included a re-examination of three components, and 18 critical issues. As a result of the audit, the rating for two components increased, Component 3, *Licensing, Certifications, Training, and Staffing* and Component 12, *Emergency Medical Response/Drills and Equipment*. The facility continues to struggle with achieving compliance for *Administrative Operations* component. Of the 18 critical issues, 9 were found resolved, and 3 new critical issues were identified.

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
Corrections Services
California Correctional Health Care Services

Enclosure

cc: Jeff Macomber, Director, Corrections Services, CCHCS
Joseph W. Moss, Chief, Contract Beds Unit (CBU), Division of Adult Institutions (DAI), California Department of Corrections and Rehabilitation (CDCR)
Edward Vasconcellos, Chief Deputy Warden, CBU, DAI, CDCR
Brian Coates, Associate Warden, CBU, DAI, CDCR
Jay Powell, Correctional Administrator, Health Care Placement Oversight Program (HCPOP) and PPCMU, Field Operations, Corrections Services, CCHCS
Joseph K. Edwards, Captain, HCPOP and PPCMU, Field Operations, Corrections Services, CCHCS
David Hill, Chief Executive Officer, Wasco State Prison, CCHCS
Anastasia Bartle, Staff Services Manager II, PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

Limited Review

Shafter Modified Community Correctional Facility

November 28, 2018

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February 15, 2019

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 Shafter Modified Community Correctional Facility (SMCCF) on June 12 through 14, 2018. The audit review period was January 2018 through April 2018. The patient population at the time of the onsite audit was 630 and the facility's budgeted capacity was 640[1]. The facility received an overall compliance rating of *Adequate* (88.4%) based on the scores compiled from each of the 14 components. Four components received a rating of Inadequate, and 18 critical issues were identified. As a result of failing one or more components and receiving an overall rating of Adequate, a limited review audit was scheduled six months after the annual audit.

[1] Data from CDCR's Weekly Population Count report, dated June 8, 2018.

The PPCMU audit team conducted a limited review audit at SMCCF on November 28, 2018. The audit review period is July 2018 through October 2018. The patient population at the time of the onsite audit was 606 and the facility's budgeted capacity was 624[2]. The audit team consisted of the following personnel:

S. Fields, Nurse Consultant, Program Review (NCPR), Retired Annuitant
C. Troughton, Health Program Manager I (A)

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

- The three failing components[3] from the annual audit
  - Component 1, *Administrative Operations,*
  - Component 3, *Licensing/Certification, Training and Staffing*
  - Component 12, *Emergency Medical Response/Drills and Equipment*
- Eighteen critical issues identified during the annual audit.

As a result of the limited review audit, the audit team found all three components improved. A comparison of the component scores between June and November 2018 audits is listed below.

Executive Summary Table

Component	Audit Type	Case Review		Overall Case Review	Quantitative Review	Overall Component
		Nurse	Provider			
1. Administrative Operations	A	N/A	N/A	N/A	74.4%	74.4% *Inadequate*
	LR	N/A	N/A	N/A	76.3%	76.3% *Inadequate*
	+/-	N/A	N/A	N/A	+1.9	+1.9
3. Licensing/ Certifications, Training, & Staffing	A	N/A	N/A	N/A	74.1%	74.1% *Inadequate*
	LR	N/A	N/A	N/A	88.5%	88.5% *Adequate*
	+/-	N/A	N/A	N/A	+14.4	+14.4
12. Emergency Medical Response/Drills and Equipment	A	N/A	N/A	N/A	75.8%	75.8% *Inadequate*
	LR	N/A	N/A	N/A	86.4%	86.4% *Adequate*
	+/-	N/A	N/A	N/A	+10.6	+10.6

[2] Data from CDCR's Weekly Population Count report, dated November 30, 2018.

[3] One of the four failing components, (11. *Preventative Services*) is only reviewed during the annual audit because it evaluates those health care services provided on an annual basis. Subsequently, this component is not part of this limited review.

In addition, the audit team found 9 of the 18 critical issues identified during the annual audit successfully resolved and identified 3 new critical issues.

Components		Critical Issues	Resolved	Unresolved	New Critical Issues
1.	Administrative Operations	2	1	1	2
2.	Internal Monitoring & Quality Management	3†	2	1†	0
3.	Licensing/Certifications, Training, and Staffing	4†	2†	2†	0
4.	Access to Care	1	0	1	0
7.	Initial Health Assessment/Health Care Transfer	1	1	0	0
8.	Medical/Medication Management	2	0	2*	0
10.	Specialty Services	1	1	0	0
11.	Preventive Services	1	0	1◊	0
12.	Emergency Medical Response/Drills & Equipment	3	2	1*	1
	Totals:	**18**	**9**	**9**	**3**

† Indicates a qualitative issue(s) related to the component.

* Indicates a critical issue was unable to be evaluated during the limited review.

◊ Indicates critical issue was not evaluated during the limited review. Component 11, Preventative Services evaluates health care services provided on an annual basis (e.g. flu vaccines and tuberculosis screening) and is audited once per year.

IDENTIFICATION OF CRITICAL ISSUES

The table below reflects all quantitative analysis standards in which the facility's compliance fell below acceptance compliance levels. 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 patients' access to health care services. During the annual audit, 18 critical issues were identified. During the limited review, auditors found 9 of the 18 critical issues resolved, 9 unresolved, and 3 new critical issues.

Critical Issues – Shafter Modified Community Correctional Facility	
Question 1.2	The facility's policies/local operating procedures are not all in compliance with the *Inmate Medical Services Policies and Procedures.* ***This is an unresolved critical issue since the June 2018 audit.***
Question 1.7	The facility does not provide patients with copies of their medical records within 15 days from the date of the initial request. ***This is a new critical issue.***
Question 1.8	The facility does not consistently document patient and/or third party requests for health care information on a CDCR Form 7385, *Authorization for Release of Information*. ***This is a new critical issue.***
Question 3.3	The facility does not consistently provide training to its health care staff. ***This is an unresolved critical issue since the June 2018 audit.***
Question 4.7	The facility does not consistently complete patient follow-up chronic care visits as ordered. ***This is an unresolved critical issue since the June 2018 audit.***
Question 8.1	The facility does not consistently provide patient chronic care medications within the specified time frame. ***This is an unresolved critical issue since the June 2017 audit.***
Question 8.5	The facility does not monitor the patient monthly while the patient is on anti-Tuberculosis medications. ***This is an unresolved critical issue since the June 2016 audit.***
Question 11.3	The facility does not consistently offer colorectal cancer screening to all patients 50 to 75 years of age. ***This is an unresolved critical issue since the June 2017 audit.***
Question 12.6	The facility nursing staff does not re-supply and re-seal the Emergency Medical Response (EMR) Bag after use during an EMR incident before the end of the shift. ***This is an unresolved critical issue since the June 2018 audit.***
Question 12.8	The facility's EMR bag does not contain all the supplies identified on the EMR Bag checklist. ***This is a new critical issue.***
Qualitative Critical Issue # 1	The facility's health care staff do not document the date of receipt and date of registered nurse triage on the CDCR Form 602 HC, *Health Care Grievance.* ***This is an unresolved critical issue since the June 2018 audit.***
Qualitative Critical Issue # 2	The facility does not consistently update the staff licensure and training log to reflect all training provided to health care staff. ***This is an unresolved critical issue since the June 2018 audit.***

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

LIMITED REVIEW AUDIT FINDINGS – FULL COMPONENT AUDIT

During the June 2018 annual audit, four components received an overall rating of *Inadequate*. Per the audit methodology contained in the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide (Revised November 2017)*, all sections of these components are reviewed during the limited review. Component 11, *Preventive Services,* is only reviewed annually and therefore is not part of this limited review. Below are the findings for Components 1, 3, and 12.

1 – ADMINISTRATIVE OPERATIONS

This component determines whether the facility's policies and local operating procedures (LOP) are in compliance with Inmate Medical Services Policies & Procedures (IMSP&P) guidelines and the contracts and service agreements for bio-medical equipment maintenance and hazardous waste removal are current. This component 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 Score: *Not Applicable*
Quantitative Review Score: *76.3%*
Overall Score: 76.3%

The compliance for this component is evaluated by auditors through the review of patient health records and the facility's policies and LOPs. Since no clinical case reviews are conducted to evaluate this component, the overall score is based entirely on the results of the quantitative review.

Quantitative Review Results

During the annual audit, the facility received a compliance score of 74.4% (*Inadequate*) with two critical issues identified. During the limited review, all questions were re-evaluated resulting in a score of 76.3% (*Inadequate*) with one prior critical issue unresolved and two additional critical issues identified. The facility achieved a 1.9 percentage point increase from the previous score. Of the eight questions reviewed, five were rated *Proficient* and three were rated *Inadequate.* Discussion of this component's critical issues are documented below.

For the annual audit, the facility submitted LOPs for 13 out of the 15 required program areas. Auditors found seven of the LOPs compliant, resulting in 46.7% compliance (Question 1.2). For the limited review audit, the facility submitted the two missing LOPs for *Aerosol Transmissible Disease Exposure Control Plan* and *Tuberculosis Surveillance Program* which were found compliant, but did not revise any of the previously non-compliant LOPs, resulting in 60% compliance. The deficiencies for the six remaining program areas are listed below.

- Access to Care - In SMCCF Policy No. 4.05, *Sick Call* (Rev. 4/18), there is no reference to the requirement to conduct Daily Care Team Huddles and document the actions and attendance of each huddle. (Reference: IMSP&P, Vol 4, Chapter 1.2, *Care Teams and Patient Panels Procedure;* City of Shafter's executed agreement with CDCR, Standard Agreement, C5607882, Scope of Work, Section I *Daily Care Team Huddle*, page 52.)

- Durable Medical Equipment (DME) - In SMCCF Policy No. 4.11, *Hospital Facilities and Equipment* (Rev. 4/18), section *Durable Medical Equipment*, the process described on pages 7 through 21, is specific to a CDCR institution and not the facility. The facility is required to create a policy specific to the facility's process, such as: how medical supplies are requested and distributed, how DME is procured and furnished to the patient, and how it is tracked by medical staff and inspected by custody staff. However, the facility failed to do so. (Reference: Per IMSP&P, Volume 4, Chapter 32.1, *Durable Medical Equipment and Supply Procedure.*)

- Health Care Staff Licensure and Training - The following deficiencies need to be addressed:

    - The SMCCF Policy No. 4.01, *Facility Physician* (Rev. 4/18) does not discuss physician peer review and annual performance appraisals. The policy does not reference the PCP is required to maintain a current Drug Enforcement Administration license and Advance Cardiac Life Support certification. Additionally, the policy does not state the physician credentialing process.

    - The SMCCF Policy No. 4.01 A, *Facility Nurse* (Rev. 4/18) does not state the Registered Nurse (RN) is required to maintain a current Basic Life Support (BLS) certification.

    - The SMCCF Policy No. 4.01 B, *Facility LVN* (Rev. 4/18) does not state the Licensed Vocational Nurse (LVN) is required to maintain a current BLS certification.

    - The SMCCF Policy No. 2.12, *Minimum Training Requirements* (Rev. 2/18) does not reference the requirement to schedule all newly hired health care staff for training at the facility's hub institution, Wasco State Prison (WSP). The policy also does not state the specifics regarding the facility's process for training its health care staff. Additionally, it does not discuss the process for tracking health care staff licenses, certifications, and training.

  (References: IMSP&P, Volume 1, Chapter 31.3, *Licensed Medical Provider Credentialing and Privileging Procedure*; City of Shafter's executed agreement with CDCR, Standard Agreement, C5607882, Scope of Work, Section Q, *Credentialing, Privileging and Peer Review,* page 57).

- Maintenance and Management of Health Records and Release of Information (ROI) - The SMCCF Policy No. 4.14, *Access to Health Care Information & Release of Information* (Rev. 4/18), is non-compliant due to the following deficiencies identified:

    - The policy does not indicate patient health records are available within CCHCS electronic Unit Health Record (e-UHR) and Electronic Health Record System (EHRS) and reference the requirement for all health care staff to access patient's historical medical information from one or both sources as necessary.

    - The specific time frame (15 business days) for completion of the ROI requests and the copying charges of 10 cents per page is not specified in the policy and it also does not state a withdrawal slip, CDC 193, needs to be completed for the amount charged to the patient.

    - There is no reference to SMCCF's process for handling patients' requests for their mental health records, Olsen reviews, and processing requests received from Attorney's office and other third parties.

    - The policy does not list all steps to be followed when collecting and processing an ROI request, namely, health care staff should date stamp the original request and CDCR Form

7385, *Authorization for Release of Information,* and document the completed date on the CDCR Form 7385 upon completion of the request, submit the patient's written request and the completed original CDCR Form 7385 to WSP for scanning into the patient's eUHR, and file copies of both documents in the patient's "shadow" file.

(Reference: IMSP&P, Volume 6, Chapters 4.1 and 4.2, *Release of Information Policy and Procedure*; City of Shafter's executed agreement with CDCR, Standard Agreement, C5607882, Scope of Work, Section W *Maintenance of Medical Records*, Page 59.)

- Medication Management - The SMCCF Policy No. 4.19, *Medication Management* (Rev. 4/18), does not state the medication availability process and time frames; medication availability refers to the time frame when the patient should receive renewed/refilled medications and newly ordered medications (Reference: IMSP&P, Volume 4, Chapter 11.2 - *Medication Orders- Prescribing Procedure.*)
- Quality Management Program - The SMCCF Policy No. 4.26, *Quality Management Program Overview* (Rev. 4/18), is not specific to the facility. The policy also does not state the frequency of the Quality Management Committee (QMC) meetings conducted at the facility. (Reference: IMSP&P, Volume 3, Chapter 1, *Quality Management Program, Institution.*)

During the annual audit, the auditors found the health care grievance information was not updated in the facility's inmate orientation handbook (Question 1.4.) The facility has successfully update the grievance section to reflect the new Health Care Grievance regulations effective September 2017. This critical issue is now considered resolved.

The auditor reviewed the two ROI requests completed during the limited review. The auditor was unable to determine if the ROIs were completed within the required time frame, as there were no nursing progress notes present in the Electronic Health Record System (EHRS) matching the date of the ROI resulting in 0.0% compliance (Question 1.7). The auditor also found one of the two requests was documented on a CDCR Form 7385 resulting in a score of 50.0% (Question 1.8). These are two new critical issues.

3 –LICENSING/CERTIFICATIONS, TRAINING & STAFFING

This component 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 certifications are current; and training requirements are met. The auditors will also determine whether clinical and custody staff are current with their emergency medical response certifications and if the facility is meeting staffing requirements specified in the contract.

Case Review Score:
Not Applicable
Quantitative Review Score: *88.5%*

Overall Score: 88.5%

This component is evaluated by the auditors through the review of facility's documentation of health care staff licenses, medical emergency response certifications, health care staff training records, and staffing information. 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, the facility received a compliance score of 74.1% (*Inadequate*) with four critical issues identified. During the limited review, all questions were re-evaluated resulting in an 88.5% (A*dequate*) with one prior critical issue unresolved. The facility achieved a 14.4 percentage point increase from the previous score. Of the six questions reviewed, five were rated *Proficient* and one rated *Inadequate.* Discussion of this component's critical issues are documented below.

During the annual audit, the auditors determined the facility was utilizing registry staff to provide weekend and holiday coverage; however, these individuals were not provided training. During the limited review, auditors found SMCCF has not provided the required training to the registry staff (Question 3.3). This critical issue remains unresolved.

Since the June 2017 annual audit, the facility has not completed a PCP peer review timely (Question 3.6.). During the limited review, the facility submitted the six month peer review for the PCP hired within the specified time frame, thus resolving this critical issue.

During the annual audit, two qualitative critical issues were identified. The facility did not document all training provided to health care staff on the log tracking health care licensing and training (Qualitative Issue #2). The facility did not track all the trainings on the training log to correspond to the training sign-in sheets. The facility also did not document the hub institution training on the training log. During the limited review, the auditors discovered the facility did not make the necessary changes to the training log. This critical issue remains unresolved. The facility did resolve Qualitative Issue #3 by affording the PCP the opportunity to obtain the suggested hub training at the WSP.

12 –EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT

Case Review Score: *Not Applicable*
Quantitative Review Score: *86.4%*
Overall Score: 86.4%

For this component, the NCPR auditors review the facility's emergency medical response documentation to assess the response time frames of the facility's health care staff during medical emergencies and/or drills. The NCPR auditors also inspect EMR bags and various emergency medical equipment to ensure regular inventory and maintenance of equipment is occurring. The compliance for this component is evaluated entirely through the review of emergency medical response documentation, inspection of emergency medical response bags and crash carts, and inspection of medical equipment located in the clinics. The clinical case reviews are not conducted for this component; therefore, the overall component score is based entirely on the results of the administrative record and onsite quantitative reviews.

Quantitative Review Results

During the annual audit, the facility received a compliance score of 75.8% (*Inadequate*) with three critical issues identified. During the limited review, all questions were re-evaluated resulting in a score of 86.4% (*Adequate*) with one prior critical issue unresolved and one new critical issue identified. The facility achieved a 10.6 percentage point increase from the previous score. Of the nine questions reviewed, seven

were rated *Proficient*, one was rated A*dequate*, and one was unable to be rated due to an insufficient sample size for the audit review period. Discussion of this component's critical issues are documented below.

During the limited review audit period, the facility did not have any emergency response and/or drills that warranted the opening of the EMR bag; therefore the auditors were unable to rate Question 12.6. This question will be monitored during subsequent audits.

While onsite for the limited review audit, the NCPR auditor inspected the EMR bag and determined the glucose was expired and the portable oxygen tank was missing the pressure gauge flow meter resulting in a non-compliant score (Question 12.8). This is a new critical issue. In addition, the NCPR auditor found the facility inventoried the EMR bag (Question 12.7) and implemented the use of a Narcan log (Question 12.15) for all four months of review period. Both critical issues are resolved.

LIMITED REVIEW AUDIT FINDINGS – PARTIAL COMPONENT AUDIT

The annual audit conducted in June 2018 resulted in the identification of 18 critical issues, 15 quantitative and 3 qualitative. During the limited review, auditors found eight quantitative and one qualitative critical issues resolved, with nine critical issue unresolved within acceptable standards. Additionally, three new critical issues were identified. The facility's progress in resolving the critical issues in Components 1, 3, and 12 are discussed in the preceding section, Limited Review Audit Findings – Full Component. The remainder are discussed below.

2 – INTERNAL MONITORING & QUALITY MANAGEMENT

During the annual audit, the facility received a quantitative compliance score of 82.9% *(Adequate*) with two quantitative and one qualitative critical issue identified for this component.

1. The CDCR Form 602 HC, *Health Care Grievance,* and CDCR Form 602 HC-A, *Health Care Grievance Attachment,* are not readily available in the housing units. (Question 2.10)

Prior Compliance	Current Compliance	Status
12.5%	100.0%	**Resolved**

During the June 2018 annual audit, auditors found the facility did not have a supply of both forms in all of the housing units. One out of the eight housing units had the CDCR Form 602 HC-A. During the limited review, the auditors found all housing units had a supply of the forms. This critical issue is resolved.

2. The facility's log for tracking health care grievances does not contain all the required information. (Question 2.12)

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

During the June 2018 annual audit, auditors found the facility was not using the current version of the grievance log. The log was missing a columns and had incorrect options in the drop down menus. During the limited review, the auditor found the facility was utilizing a corrected log. This critical issue is resolved.

3. The facility's health care staff do not document the date of receipt and date of registered nurse triage on the CDCR Form 602 HC, *Health Care Grievance*. (Qualitative Critical Issue #1)

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

During the June 2018 annual audit, the nursing staff did not date stamp the receipt date on the CDCR Form 602 HC, nor did they note the date the grievance was triaged. During the limited review, auditors found one health care grievance on their health care grievance log for the audit

review period; however, the facility could not supply a copy of the grievance. This critical issue could not be evaluated and remains unresolved.

4 – ACCESS TO CARE

During the annual audit, the facility received a quantitative compliance score of 93.1% *(Proficient*) with one critical issue identified for this component.

1. The facility does not consistently complete patient follow-up chronic care visits as ordered. (Question 4.7)

Prior Compliance	Current Compliance	Status
75.0%	75.0%	**Unresolved**

During the annual audit, auditors found 12 of 16 patient health records had documentation of a chronic care visit completed as ordered by the PCP. During the limited review, auditors again found 12 of 16 records had documentation of the chronic care visit as ordered. This remains a critical issue.

7 – INITIAL HEALTH ASSESSMENT/HEALTH CARE TRANSFER

During the annual audit, the facility received a quantitative compliance score of 83.3% *(Adequate*) with one critical issue identified for this component.

1. The facility's nursing staff is not knowledgeable about the documents to be included in a patients Transfer Envelope. (Question 7.8)

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

During the annual audit, the auditor interviewed one RN regarding the transfer process. The RN was not knowledgeable about the documents to be included in the transfer envelope. During the limited review, the auditor interviewed three RNs who all knew the proper documents to be included in the transfer envelope. This critical issue is resolved.

8 – MEDICAL/MEDICATION MANAGEMENT

During the annual audit, the facility received a quantitative compliance score of 97.5% *(Proficient*) with two critical issues identified for this component.

1. The facility does not consistently provide patient chronic care medications within the specified time frame. (Question 8.1)

Prior Compliance	Current Compliance	Status
75.0%	62.5%	**Unresolved**

This critical issue was identified during the June 2017 audit. The facility received a compliance score of 41.7%. During both the December 2017 and June 2018 audits, the auditor found the facility was 43.8% and 75.0% compliant, respectively. During the limited review, the auditor found 10 of the 16 patients in the sample were given their chronic care medications within the required time frame. This remains a critical issue.

2. The facility does not monitor the patient monthly while the patient is on anti-Tuberculosis medications. (Question 8.5)

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

During the annual and limited review audits SMCCF did not have any patients receiving anti-Tuberculosis medications. Therefore this question could not be evaluated for compliance and will be monitored for compliance during subsequent audits. This is an unresolved critical issue from the June 2016 audit.

10 – SPECIALTY SERVICES

During the annual audit, the facility received a quantitative compliance score of 76.6% *(Inadequate*) with one critical issue identified for this component.

1. The facility's PCP does not consistently review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patients within the required time frame. (Question 10.4)

Prior Compliance	Current Compliance	Status
37.5%	100.0%	**Resolved**

During the annual audit, the auditor found three of eight patient health records showed the PCP completed a follow-up appointment with the patient within the required time frame. During the limited review, the auditor found all patient were seen by the PCP in the specified time frame. This critical issue is resolved.

CONCLUSION

During the limited review audit, Components 1, 3, and 12 were re-evaluated in addition to 18 critical issues identified during the June 2018 Annual Audit. As a result, two of the three components reviewed received an adequate rating, nine critical issues were found resolved, and three new critical issues were identified.

The facility showed improvement in Component 3, *Licensing/Certifications, Training, and Staffing* and Component 12, *Emergency Medical Response/Drills and Equipment*. The facility continues to struggle with achieving compliance in Component 1, *Administrative Operations*. The areas of non-compliance are as follows:

- The facility's LOPs are not all in compliance with the IMSP&P.
- Copies of patient requested medical records are not provided within the specified time frame.
- Health care staff are not consistently using the CDCR Form 7385, *Authorization for Release of Information*.
- The facility does not consistently update the staff licensure and training log.
- Training is not provided to registry nursing staff.
- Chronic care visits are not consistently completed as ordered.
- Chronic care medications are not consistently provided to patients as ordered.

During the course of the limited review the auditors reviewed the findings with the staff at SMCCF. There was no formal exit at the facility as this was a very limited review.

APPENDIX A – QUANTITATIVE REVIEW RESULTS – Critical Issues Only

1. Administrative Operations		Audit Type	Yes	No	Compliance	Change
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	A	3	0	100.0%	0.0
		LR	4	0	100.0%	
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	7	8	46.7%	+13.3
		LR	9	6	60.0%	
1.3	Does the facility have current contracts/service agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	A	3	0	100.0%	0.0
		LR	3	0	100.0%	
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance processes?	A	0	1	0.0%	+100.0
		LR	1	0	100.0%	
1.5	Does the facility's provider(s) access the California Correctional Health Care Services patient electronic medical record system regularly?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
1.6	Does the facility maintain a Release of Information log that contains ALL the required data fields and all columns are completed?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
1.7	Did the facility provide the requested copies of medical records to the patient within 15 business days from the date of the initial request?	A	N/A	N/A	N/A	N/A
		LR	0	2	0.0%	
1.8	Are all patient and/or third party written requests for health care information documented on a CDCR Form 7385, *Authorization for Release of Information*, and copies of the forms filed in the patient's electronic medical record?	A	N/A	N/A	N/A	N/A
		LR	1	1	50.0%	
	Overall Percentage Score and Change			**Annual**	**74.4%**	+1.9
				Limited Review	**76.3%**	

Comments:

1.2 Six of the facility's health care policies reviewed were found to be non-compliant with IMSP&P: the *Access to Care; Durable Medical Equipment and Medical Supplies; Health Care Staff Licensure; Training and Staffing; Maintenance and Management of Health Records and Release of Information; Medications Management; and Quality Management Program*.

1.7 The auditor reviewed two requests for health records during the audit review period. The auditor was unable to verify the patients received the records within the required time frame for both requests.

1.8 The auditor was unable to find one of the CDCR Forms 7385 in the EHRS for the two health record requests during the audit review period.

2. Internal Monitoring & Quality Management		Audit Type	Yes	No	Compliance	Change
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	1	7	12.5%	+87.5
		LR	8	0	100.0%	
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%	

Comments:

None

3. Licensing/Certifications, Training & Staffing		Audit Type	Yes	No	Compliance	Change
3.1	Are all health care staff licenses current?	A	16	0	100.0%	0.0
		LR	13	0	100.0%	
3.2	Are health care and custody staff current with required emergency medical response certifications?	A	81	0	100.0%	0.0
		LR	76	0	100.0%	
3.3	Does the facility provide the required training to its health care staff?	A	4	5	44.4%	-13.6
		LR	4	9	30.8%	
3.4	Is there a centralized system for tracking all health care staff licenses and certifications?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
3.5	Does the facility have the required health care and administrative staffing coverage per contractual requirement?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
3.6	Are the peer reviews of the facility's providers completed within the required time frames?	A	0	1	0.0%	+100.0
		LR	1	0	100.0%	
	Overall Percentage Score and Change:		**Annual**		**74.1%**	**+14.4**
			Limited Review		**88.5%**	

Comments:

3.3 The facility did not provide health care training to registry staff who were scheduled to provide weekend and vacation coverage.

4. Access to Care		Audit Type	Yes	No	Compliance	Change
4.7	Was the patient's chronic care follow-up visit completed as ordered?	A	12	4	75.0%	0.0
		LR	12	4	75.0%	

Comments:

4.7 Of the 16 patient health records reviewed, 4 records showed patients' chronic care visits were not consistently completed as ordered.

7. Initial Health Assessment/Health Care Transfer		Audit Type	Yes	No	Compliance	Change
7.8	Does the Inter-Facility Transfer Envelope contain all the required transfer documents and medications?	A	0	1	0.0%	+100.0
		LR	3	0	100.0%	

Comments:

None.

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	12	4	75.0%	-12.5
		LR	10	6	62.5%	
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	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	

Comments:

8.1 Of the 16 patient health records reviewed, six records did not have documentation the patient received their chronic care medication within the required time frame.

8.5 There were no patients receiving anti-TB medications during the limited review period.

10. Specialty Services		Audit Type	Yes	No	Compliance	Change
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	3	5	37.5%	+62.5
		LR	9	0	100.0%	

Comments:

None.

12. Emergency Medical Response/Drills & Equipment		Audit Type	Yes	No	Compliance	Change
12.1	Did the facility conduct emergency medical response drills quarterly on each shift when medical staff was present during the most recent full quarter?	A	3	0	100.0%	0.0
		LR	3	0	100.0%	
12.2	Did a registered nurse, a mid-level provider, or a primary care provider respond within eight minutes after emergency medical alarm was sounded?	A	12	0	100.0%	0.0
		LR	11	0	100.0%	
12.3	Did the facility hold an Emergency Medical Response Review Committee meeting a minimum of once per month?	A	4	0	100.0%	0.0
		LR	5	0	100.0%	

12.4	Did the Emergency Medical Response Review Committee perform timely incident package reviews that included the use of required review documents?	A	10	2	83.3%	+16.7
		LR	11	0	100.0%	
12.5	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	A	90	0	100.0%	-2.2
		LR	91	2	97.8%	
12.6	If the emergency medical response and/or drill warranted an opening of the Emergency Medical Response Bag, was it re-supplied and re-sealed before the end of the shift?	A	0	1	0.0%	N/A
		LR	N/A	N/A	N/A	
12.7	Was the Emergency Medical Response Bag inventoried at least once a month?	A	3	1	75.0%	+25.0
		LR	4	0	100.0%	
12.8	Did the Emergency Medical Response Bag contain all the supplies identified on the facility's Emergency Medical Response Bag Checklist?	A	1	0	100.0%	-100.0
		LR	0	1	0.0%	
12.9	Was the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.10	If the emergency medical response and/or drill warranted an opening and use of the Medical Emergency Crash Cart, was it re-supplied and re-sealed before the end of the shift? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.11	Was the Medical Emergency Crash Cart inventoried at least once a month? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.12	Does the facility's Medical Emergency Crash Cart contain all the medications as required/approved per *Inmate Medical Services Policies and Procedures*? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.13	Does the facility's Medical Emergency Crash Cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.14	Does the facility have the emergency medical equipment that is functional and operationally ready?	A	5	0	100.0%	-20.0
		LR	4	1	80.0%	
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	1	0.0%	+100
		LR	93	0	100.0%	
	Overall Percentage Score and Change:			**Annual**	**75.8%**	**+10.6**
				Limited Review	**86.4%**	

Comments:

12.5 On October 1 and 21, 2018, the RN on the evening shift did not check the EMR bag.

12.6 During the limited review audit period, the facility did not have any emergency responses and/or drills that warranted the opening of the EMR bag.

12.8 The EMR bag contained expired glucose and the oxygen tank was missing the pressure gauge flow meter.

12.14 The portable oxygen tank in the EMR bag was not functional and was non-operational.

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 SMCCF are summarized in the table below.

Please note 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:

During the onsite limited review, the auditors interviewed 11 IAC members and two patients designated as part of the Disability Placement Program. The members of the IAC were interviewed on health care services provided at SMCCF, none of the members had issues with the medical care provided to them. The two DPP patients were interviewed and they did not have any issues.

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 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, this 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, this 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 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.