July 25, 2016

Wanda Wilson, Warden
Golden State Modified Community Correctional Facility
611 Frontage Street
McFarland, CA 93250

Dear Warden Wilson,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at Golden State Modified Community Correctional Facility (GSMCCF) on May 2 through 4, 2016. The purpose of this audit was to ensure that GSMCCF is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On June 27, 2016, a draft report was sent to you providing the opportunity to review and dispute any findings presented in the draft report. On July 9, 2013, your facility submitted responses disputing 13 of the audit findings. The attached document reflects 2 of 13 quantitative items have been reconsidered. Acceptance of these disputes has resulted in the removal of 1 item from the *Identification of Critical Issues* section and the updated score to question 4.8 in the *Access to Care* section. Refer to the attached documents for CCHCS's detailed response to questions and items disputed by GSMCCF.

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

The facility should be commended on maintaining 100% compliance on the 14 prior critical issues; none of which have been reopened during this current audit. However, the audit findings revealed that two quality indicators, *Health Appraisal/Health Care Transfer* and *Specialty Services* did not meet the standard of care. In addition, a number of minor deficiencies were identified in the following quality indicators and require facility's immediate attention and resolution:

- Internal Monitoring and Quality Management
- Licensing/Certification, Training & Staffing
- Emergency Medical Response/Drills & Equipment

These deficient areas listed above can be brought to compliance by the facility's strict adherence to the established policies and procedures outlined in the *Inmate Medical Services Policies and Procedures* and the contract.

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

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

Enclosure

cc: John Dovey, Director, Corrections Services, CCHCS
Joseph W. Moss, Chief, Contract Beds Unit, California Out of State Correctional Facility, DAI, CDCR
Michael J. Williams, Chief Deputy Administrator, Contract Beds Unit, COCF, DAI, CDCR
Ted Kubicki, Chief Executive Officer, North Kern State Prison, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

Golden State Modified Community Correctional Facility

May 2-4, 2016

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July 25, 2016

INTRODUCTION

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

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

This report provides the findings associated with the onsite audit conducted between May 2 and 4, 2016, at Golden State Modified Community Correctional Facility (GSMCCF), located in McFarland, California, as well as findings associated with the review of various documents and patient medical records for the review period of October 2015 through March 2016. At the time of the audit, CDCR's *Weekly Population Count*, dated Friday, April 29, 2016, indicated a budgeted bed capacity of 700 beds, of which 667 were occupied with CDCR patients.

EXECUTIVE SUMMARY

From May 2 through 4, 2016, the CCHCS audit team conducted an onsite health care monitoring audit at GSMCCF. The audit team consisted of the following personnel:

G. Song, MD, Regional Physician Advisor
L. Pareja, RN, MSN, Nurse Consultant Case Review
C. Troughton, Health Program Specialist I

The audit included two primary sections: a *quantitative* review of established performance measures and a *qualitative* review of health care staff performance and quality of care provided to the patient

population at GSMCCF. The end product of the quantitative review is expressed as a compliance score, while the end product of clinical case reviews is a quality rating.

The CCHCS rates each of the operational areas based on case reviews conducted by CCHCS physicians and registered nurses, medical record reviews conducted by registered nurses, and onsite reviews conducted by CCHCS physician, registered nurse, and Health Program Specialist I auditors. The ratings for every applicable indicator may be derived from the clinical case review results alone, the medical record and/or onsite audit results alone, or a combination of both of these information sources (as shown in the *Executive Summary Table* below).

Based on the quantitative reviews and clinical case reviews completed for the 15 operational areas/quality indicators during the audit, GSMCCF achieved an overall point value of ***0.9*** which resulted in an overall audit rating of **inadequate.**

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

Executive Summary Table

Operational Area/Quality Indicator	Case Review Rating	Quantitative Review Score	Quantitative Review Rating	Overall Indicator Rating	Points Scored
1. Administrative Operations	N/A	97.1%	Proficient	Proficient	2
2. Internal Monitoring & QM	N/A	79.9%	Inadequate	Inadequate	0
3. Licensing/Certification, Training & Staffing	N/A	82.5%	Inadequate	Inadequate	0
4. Access to Care	Adequate	89.4%	Adequate	Adequate	1
5. Chronic Care Management	Adequate	63.3%	Inadequate	Adequate	1
6. Community Hospital Discharge	N/A	N/A	N/A	N/A	N/A
7. Diagnostic Services	Adequate	95.6%	Proficient	Adequate	1
8. Emergency Services	Adequate	N/A	N/A	Adequate	1
9. Health Appraisal/Health Care Transfer	Inadequate	80.9%	Inadequate	Inadequate	0
10. Medication Management	Adequate	95.1%	Proficient	Proficient	2
11. Observation Cells	N/A	N/A	N/A	N/A	N/A
12. Specialty Services	Inadequate	64.6%	Inadequate	Inadequate	0
13. Preventive Services	N/A	100.0%	Proficient	Proficient	2
14. Emergency Medical Response/Drills & Equipment	N/A	80.8%	Inadequate	Inadequate	0
15. Clinical Environment	N/A	99.3%	Proficient	Proficient	2
16. Quality of Nursing Performance	Adequate	N/A	N/A	Adequate	1
17. Quality of Provider Performance	Adequate	N/A	N/A	Adequate	1
				Average	0.9
				Overall Audit Rating	Inadequate

NOTE: For specific information regarding any non-compliance findings indicated in the tables above, please refer to the Identification of Critical Issues (located on page 11 of this report), or to the detailed audit findings by quality indicator (located on page 13) sections of this report.

BACKGROUND AND PROCESS CHANGES

In April of 2001, inmates, represented by the Prison Law Office, filed a class-action lawsuit, known as *Plata vs. Schwarzenegger*, alleging their constitutional rights had been violated as a result of the CDCR health care system's inability to properly care for and treat 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. The court's intent is to remove the receivership and return operational control to CDCR as soon as the health care delivery system is stable, sustainable and provides for constitutionally adequate levels of health care.

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

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

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

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

Additionally, clinical case review section has been added to the audit process. This will help CCHCS to better assess and evaluate the timeliness and quality of care provided by nurses and physicians at the

contract facilities. The ratings obtained from these reviews will be utilized to determine the facility's overall performance for all *medical quality indicators* section. The resulting quality ratings from the case reviews will be incorporated with the quantitative review ratings to arrive at the overall audit rating and will serve as the sole decisive factor for determining compliance for some of the operational areas whereas for some of the other operational areas, case review ratings will play a dominant role in determining the overall compliance.

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

Quantitative Review

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

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 14 medical and 3 administrative indicators of health care to measure. The medical components cover clinical categories directly relating to the health care provided

to patients, whereas the administrative components address the organizational functions that support a health care delivery system.

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

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

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

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

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

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

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

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

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

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

Qualitative Review

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

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

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

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

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

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

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

Overall Quality Indicator Rating

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

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

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

Overall Audit Rating

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

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

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

- **Proficient** - Since the cut-off value for a proficient rating in the quantitative review is 90.0% and the highest available point value for quality rating is 2.0, the threshold value range is calculated by multiplying the highest available points by 90.0%, which is: 2.0 X 90.0% = 1.8. This value is a *constant* and has been determined to be the minimum value required to achieve a rating of *proficient.* Therefore, any overall score/value of 1.8 or higher will be rated as *proficient*. This is designed to mirror the performance standard established in the quantitative review (i.e., 90.0% of the maximum available point value of 2.0).

- **Adequate** - A threshold value of 1.0 has been determined to be the minimum value required to achieve a quality rating of *adequate*. Therefore, any value falling between 1.0 and 1.7 will be rated as *adequate*.

- **Inadequate** - A threshold value falling between the range of 0.0 and 0.9 will be assigned a rating of *inadequate*.

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

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

Scoring for Non-Applicable Questions and Double-Failures:

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

Resolution of Critical Issues

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

IDENTIFICATION OF CRITICAL ISSUES

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

Critical Issues – Golden State Modified Community Correctional Facility	
Question 1.7	Signed Release of Information Forms were not contained in the electronic medical record for all patients whose names were on the Release of Information Log.
Question 2.2	The facility's Quality Management Committee review does not consistently document the corrective action plan for the identified opportunities for improvement.
Question 2.3	The facility's Quality Management Committee review process does not consistently provide documentation on the aspects of care.
Question 2.4	The facility does not submit all monitoring logs by the required scheduled date.
Question 2.5	The facility does not accurately document all the dates on the sick call monitoring log.
Question 2.6	The facility does not accurately document all the dates on the specialty care monitoring log.
Question 2.9	The facility does not accurately document all the dates on the initial intake screening monitoring log.
Question 2.13	The facility does not process all health care appeals within the required time frames.
Question 3.2	The facility's custody staff are not all current on their cardiopulmonary resuscitation certification.
Question 3.9	The peer review of the facility's Primary Care Provider (PCP) is not being completed within the required time frame.
Question 4.5	The registered nurses do not consistently conduct a focused subjective/objective assessment based upon the patient's chief complaint.
Question 4.8	The registered nurses do not consistently document that effective communication was established and that education was provided to the patient related to the treatment plan.
Question 5.3	The RN does not document on the CDCR Form 7225, *Refusal of Examination and/or Treatment* or similar form, when a patient refuses his chronic care keep-on-person medications.
Question 7.4	The PCP does not consistently see the patient for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results.
Question 9.1	The facility does not consistently provide patients with an initial health screening upon their arrival at the facility.
Question 9.8	The patients do not consistently receive a complete screening for the signs and symptoms of tuberculosis upon their arrival at the facility.

Question 9.11	The registered nurses do not consistently document scheduled specialty services appointments that were not completed on a CDCR Form 7371, *Health Care Transfer Information,* when the patient transfers out of the facility.
Question 10.7	The Licensed Vocational nurse could not articulate which forms to use when a medication error arises.
Question 12.3	The registered nurses do not consistently complete a face-to-face assessment of the patient upon his return from a specialty consult appointment, hub or community hospital emergency department visit.
Question 12.4	The facility does not consistently document that upon a patient's return from a specialty consult appointment, hub or community hospital emergency department visit, a registered nurse notified the PCP of any immediate orders or follow-up instructions provided by the hub, a specialty consultant, or emergency department physician.
Question 14.5	The facility failed to consistently submit the required documentation with the Emergency Medical Response Review Committee (EMRRC) meeting minutes.
Question 14.8	The facility's EMR bag is not consistently inventoried monthly, if the emergency medical response and/or drill did not warrant an opening of the bag.
Question 14.9	The facility's EMR Bag was not organized according to the audit checklist.

NOTE: A discussion of the facility's progress toward resolution of all critical issues identified during *previous* health care monitoring audits is included in the *Prior Critical Issue Resolution* portion on page 45 of this report.

AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR

1. ADMINISTRATIVE OPERATIONS

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
97.1% [*Proficient*]
Overall Rating:
Proficient

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

The facility received a compliance score of 97.1% in the *Administrative Operations* indicator, equating to an overall rating of *proficient*.

The auditors discussed the facility's need to create a process for tracking loose documents that are sent to the hub facility for uploading into the electronic unit health record (eUHR). The auditors discovered that copies of three non-compliant CDCR Form 7385, *Authorization for Release of Information,* were present in the patients' shadow medical file stored at the facility but could not be located in the eUHR. The HPS I contacted the Health Records Technician II (HRT II) at the hub and requested that the three copies be uploaded into the eUHR, the HRT II obliged and GSMCCF forwarded the three photocopies of the 7385 forms to the hub facility. Post audit all three 7385's have been uploaded into the eUHR.

The auditors also discovered GSMCCF was inconsistent in assessing fees for producing photocopies of patients' medical records upon their request for release of information; patients were being charged 10¢, 12¢ and 15¢. The HPS I auditor discussed this with the HSA, who stated that she was having a disagreement with the clerk in Inmate Accounts, who insisted on charging these amounts. The HSA and auditor had a discussion with the clerk informing her that GSMCCF's Release of Information LOP, which is in compliance with CDCR's IMSP&P, dictates that patients are to be charged 10¢ per copy. The clerk stated that she would return the overpaid monies to the patients and process the charge of 10¢ per copy for all future requests.

Quantitative Review Results

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

Administrative Operations		Yes	No	Compliance
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	4	0	100%
1.2	Does the facility have written health care policies and/or procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	15	0	100%
1.3	Does the facility have current contracts/agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	3	0	100%
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	2	0	100%
1.5	Does the facility's health care staff access the California Correctional Health Care Services patient's electronic medical record?	10	0	100%
1.6	Does the facility maintain a Release of Information log that contains all the required data fields?	1	0	100%
1.7	Are all patients' written requests for health care information documented on a CDCR Form 7385, *Authorization for Release of Information*, and scanned/filed into the patient's medical record?	16	4	80.0%
1.8	Are all written requests from third parties for release of patient medical information accompanied by a CDCR Form 7385, *Authorization for Release of Information*, from the patient and scanned/filed into the patient's medical record?	Not Applicable		
	Overall Quantitative Review Score:			**97.1%**

Comments:

1. Question 1.7 – During the audit review period of October 2015 through March 2016; 38 patients requested health care information, of which 20 were randomly selected to affirm that the CDCR Form 7385, *Authorization of Release of Information* was viewable in the patient's eUHR. Sixteen of the patient's medical records contained a signed release of information for their medical records. Four patient records did not contain a signed release. This equates to 80.0% compliance.
2. Question 1.8 – Not Applicable. During the audit review period of October 2015 through March 2016, the facility had 16 third party requests from the Department of State Hospitals (DSH). However, due to the nature of the requests, the patients were not required to sign a release of information for DSH access to the medical record. There were no other third party requests for release of health care information received during the audit review period; therefore this question could not be evaluated.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
79.9% [*Inadequate*]
Overall Rating:
Inadequate

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

patient medical appeals and appropriately addresses all appealed issues.

In addition, the facilities are required to utilize monitoring logs (provided by PPCMU) to document and track all patient medical encounters such as initial intake, health appraisal, sick call, chronic care, emergency/hospital services and specialty care services. These logs are reviewed by PPCMU staff on a monthly or a weekly basis to ensure accuracy, timely submission and whether the facility meets time frames specified in IMSP&P for each identified medical service. Rating of this quality indicator is based entirely on the quantitative review results from the assessment of patient medical records, QMC meeting minutes, patient first level health care appeals and responses and the facility's monitoring logs.

GSMCCF received a compliance rating of 79.9% in the *Internal Monitoring and Quality Management* indicator, equating to an overall quality rating of *inadequate.* As mentioned in the Comments section below and evidenced by the unacceptable scores to the monitoring log questions, the facility's struggle is with the timely submission and accuracy of the dates of service documented on the logs. During the month of October 2015, no monitoring logs were submitted on the required dates; monitoring logs were not submitted timely 56.7% of the time.

Another component that GSMMCF is struggling with is first level health care appeals, the facility cannot decipher the difference between a CDCR 22, *Inmate/Parole Request for Interview, Item or Service* and *CDCR Form 602-HC, Patient-Inmate Health Care Appeal* (Rev. 6/13) . As all CDCR 22 and 602 HC appeals are being logged on the same log, the HPS I conversed with the HSA and reiterated that first level health care appeals are the only appeals that should be logged on the first level health care appeal log.

Although GSMCCF is holding monthly QMC meetings, during the month of October 2015, the staff failed to document corrective action plans for identified opportunities of improvement as well as monitoring aspects of care. In the subsequent five months, GSMCCF made significant improvements.

Quantitative Review Results

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

Internal Monitoring & Quality Management		**Yes**	**No**	**Compliance**
2.1	Does the facility hold a Quality Management Committee a minimum of once per month?	6	0	100%
2.2	Does the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	5	1	83.3%
2.3	Does the Quality Management Committee's review process include monitoring of defined aspects of care?	5	1	83.3%
2.4	Does the facility submit all monitoring logs (sick call, specialty care, hospital stay/emergency department, chronic care and initial intake screening) by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	51	39	56.7%
2.5	Are the dates documented on the sick call monitoring log accurate?	41	11	78.8%
2.6	Are the dates documented on the specialty care monitoring log accurate?	14	4	77.8%
2.7	Are the dates documented on the hospital stay/emergency department	2	0	100%

	monitoring log accurate?			
2.8	Are the dates documented on the chronic care monitoring log accurate?	53	7	88.3%
2.9	Are the dates documented on the initial intake screening monitoring log accurate?	42	18	70.0%
2.10	Are the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* readily available to patients in all housing units?	8	0	100%
2.11	Are patients able to submit the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* on a daily basis in all housing units?	8	0	100%
2.12	Does the facility maintain a CCHCS Health Care Appeals log and does the log contain all the required information?	1	0	100%
2.13	Are the first level health care appeals being processed within specified time frames?	0	1	0.0%
	Overall Quantitative Review Score:			**79.9%**

Comments:

1. Question 2.2 – Of the six required Quality Management meetings during the audit review period, the staff failed to document any identified opportunities of improvement on the October 2015 meeting notes. This equates to 83.3% compliance.
2. Question 2.3 - Of the six required Quality Management meetings during the audit review period, the month of October 2015 meeting notes did not define the aspects of care. This equates to 83.3% compliance.
3. Question 2.4 – During the audit review period of October 2015 through March 2016, 90 submissions of monitoring logs were required. Of the 90 monitoring logs submitted, 51 were submitted on time. This equates to 56.7% compliance. See table below for additional information and details.

Type of Monitoring Log	Required Frequency of Submission	Number of Required Submissions for the Audit Review Period	Number of Timely Submissions	Number of Late Submissions
Sick Call	weekly	26	14	12
Specialty Care	weekly	26	13	13
Hospital Stay/Emergency Department	weekly	26	14	12
Chronic Care	monthly	6	5	1
Initial Intake Screening	monthly	6	5	1
	Totals:	**90**	**51**	**39**

4. Question 2.5 – A total of 52 entries were randomly selected from the weekly sick call monitoring logs to assess the accuracy of the dates documented on the log. Of the 52 entries reviewed, 41 were found to be accurate with dates matching the dates of services reflected in the patients' medical records. This equates to 78.8% compliance The 11 discrepancies are as follows:
    - Patient's CDCR number did not match the name of the patient. (2 instances)
    - No dates were documented on the log when an RN referred the patient to the Primary Care Provider (PCP) for a Face-to-Face (FTF) appointment. (4 instances)
    - Date of Registered Nurse (RN) FTF as documented on the log differed from the date in the eUHR. (2 instances)

- Date of the PCP FTF with the patient as documented on the log differed from the eUHR. (1 instance)
- Date the sick call slip was received as documented on the log differed than the date in the eUHR. (1 instance)
- No documentation in the eUHR to validate dates on the log. (1 instance)

5. Question 2.6 – A total of 18 entries were randomly selected from the weekly specialty care monitoring logs to assess the accuracy of the dates documented on the log. Of the 18 entries reviewed, 14 were found to be accurate with dates matching the dates of services reflected in the patients' medical records. In the remaining four deficient entries; one entry had no documented dates of RN or PCP FTF after patient's specialty care appointment, one entry did not have documentation in the eUHR that the patient was seen by an RN after his specialty care appointment, one entry had the wrong documented date on the log, in which the PCP saw the patient after his specialty care appointment and the final deficient entry did not have a Request for Services (CDCR form 7326) in the eUHR. This equates to 77.8% compliance.

6. Question 2.8 – A total of 60 entries were randomly selected from the monthly chronic care monitoring logs to assess the accuracy of the dates reported on the logs. Of the 60 entries reviewed, 53 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. Of the seven deficient entries; three entry dates documented on the log did not correlate with the dates in the eUHR; two entries reflected the patients were not seen for their chronic care issues; one entry did not have documentation in the eUHR to support that the patient had been seen for his chronic care appointment; and one record did not have documentation in the eUHR to support the date of the patient's next chronic care appointment. This equates to 88.3% compliance.

7. Question 2.9 – A total of 60 entries were randomly selected from the monthly initial intake screening monitoring log to assess the accuracy of the dates reported on the logs. Of the 60 entries reviewed, 42 were found to be accurate with dates matching the dates of services reflected in the patients' medical records. Of the remaining 18 entries, 15 entries were found deficient as a result of no CDCR Form 7277 in the eUHR; one patient's CDCR number did not match the name of the patient; one entry had the wrong nursing assessment date; and one did not have documentation in the eUHR supporting the PCP saw the patient. This equates to 70.0% compliance.

8. Question 2.13 – As stated above GSMCCF is struggling with deciphering the difference between a CDCR 22, *Inmate/Parole Request for Interview, Item or Service* and *CDCR Form 602-HC, Patient-Inmate Health Care Appeal (Rev. 6/13).* During the audit review period, GSMCCF documented nine first level health care appeals on the First Level Health Care Appeal log. Of the nine appeals, four were dental appeals and forwarded onto the appropriate dental entities for response. Of the remaining five first level health care appeals; four should not have been logged as they were completed on a CDCR 22 form, the remaining one appeal was submitted on the CDCR 602-A, *Inmate/Parole Appeal Form Attachment* and should have been rejected for incompleteness. As a result of no CDCR 602-HC attached to the CDCR 602-A*;* auditors could not determine if the facility responded to the appeal in a timely manner as there was no date documented on the response. This equates to 0.0% compliance.

3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
82.5% [*Inadequate*]
Overall Rating:
Inadequate

This indicator is evaluated by CCHCS 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. No clinical case reviews are conducted for this indicator; therefore, the overall rating is based entirely on the results of the quantitative review.

GSMCCF received a compliance rating of 82.5% compliance in the *Licensing/Certifications Training & Staffing* indicator, resulting in an overall rating of ***inadequate.*** Five of the seven questions assessed in this component scored 100%, which is in the proficient range. Although GSMCCF received a passing score on five of the seven questions; their disregard of not providing an annual peer review on the PCP has significantly impacted their score. At the time of the onsite audit, GSMCCF contacted Correct Care Solutions (CCS; the contractor they use to provide medical oversight at the facility) to procure the peer review. During the exit conference the auditors reiterated the facility's blatant disregard for the peer review process and their need to submit the severely overdue review immediately.

Quantitative Review Results

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

Licensing/Certifications, Training, & Staffing		Yes	No	Compliance
3.1	Are all health care staff licenses current?	10	0	100%
3.2	Are health care and custody staff current with required medical emergency response certifications?	122	36	77.2%
3.3	Did all health care staff receive training on the facility's policies based on Inmate Medical Services Policies and Procedures requirements?	10	0	100%
3.4	Is there a centralized system for tracking licenses, certifications, and training for all health care staff?	2	0	100%
3.5	Does the facility have the required provider staffing complement per contractual requirement?	1	0	100%
3.6	Does the facility have the required nurse staffing complement per contractual requirement?	5.2	0	100%

3.7	Does the facility have the required clinical support staffing complement per contractual requirement? (COCF Only)?	Not Applicable		
3.8	Does the facility have the required management staffing complement per contractual requirement? (COCF Only)	Not Applicable		
3.9	Are the peer reviews of the facility's providers completed within the required time frames?	0	1	0.0%
	Overall Quantitative Review Score:			**82.5%**

Comments:

1. Question 3.2 – A total of 10 health care staff and 148 custody staff members were assessed for compliance with the required medical emergency response certifications. All health care staff had current emergency response certifications. Of the 148 custody staff members assessed, 112 had current CPR certifications and 36 had certifications that were expired. This equates to 77.2% compliance. As the facility was found less than 100% compliant with this requirement, it is identified as a critical issue and will be evaluated during the subsequent audit. It should be noted that the facility has rectified this deficiency and all 36 custody staff members with expired certificates have been recertified and have current certificates as of May 9, 2016.
2. Questions 3.7 and 3.8 – Not Applicable. These questions are not applicable to in-state correctional facilities.
3. Question 3.9 –The facility has not performed a peer review on the PCP in the last year. The facility conducted the last peer review on the PCP on November 3, 2014. This equates to 0.0% compliance.

4. ACCESS TO CARE

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
89.4% [*Adequate*]
Overall Rating:
Adequate

For *Access to Care*, the case review and the quantitative review resulted in similar findings. The quantitative review resulted in an overall score of 89.4%, mainly as a result of nursing staff not documenting effective communication during face-to-face encounters and not performing a focused subjective/objective assessment of the patient's chief complaint. During the case reviews both nursing and physicians performed at the adequate level. Overall, GSMCCF rated *adequate* in the *Access to Care* indicator.

Case Review Results

The CCHCS clinicians reviewed a total of 129 provider and nursing encounters related to *Access to Care*; 76 nursing encounters and 53 provider encounters. Out of the 129 encounters, 35 deficiencies were identified, of which 13 were related to nursing performance and 22 were related to provider performance. The deficiencies identified during the nursing case review are as follows:

- In Case 8, nursing staff did not take appropriate nursing action related to the patient's medical complaint. The patient, who had a history of liver problems and complained of lower back pain and upon nursing assessment, the patient was prescribed Acetaminophen.
- In Cases 1, 4 and 5, nursing staff did not review the CDCR Form *7362, Health Care Services Request*, or similar form on the day it was received.
- In Cases 1, 3 and 6, nursing staff did not complete an adequate assessment of the patients' chief medical complaint.
- In Cases 3 and 4, the nursing staff did not formulate a correct and proper nursing diagnosis based on the formulation of nursing standards; related to all the collected data and information.
- In Case 8, unable to locate the CDCR Form *7362, Health Care Services Request*, or similar form, nursing notes and nursing assessment in the eUHR related to the patients chief complaint.
- In Case 6, the patient received Durable Medical Equipment (DME) (eyeglasses); however nursing staff failed to document the DME that the patient received.
- In Case 11, effective communication was not documented.

The physician deficiencies identified were:

- In Case 1 the document was difficult to read; borderline illegible and in Case 3, the document was hard to read.
- In Cases 1, 14 and 15, the PCP did not document why a lower bunk chrono was given to the patient. Also in Case 15, the PCP did not address with the patient that soft shoe chrono's no longer exist.
- In Cases 1, 3, 4, 6, 7, 14 and 15, there was either missing or incomplete documentation to support the actions taken by the provider. For example, in Case 1, the patient was seen for chronic knee pain and acne. The PCP mentions that the patient has new onset skin lesions and prescribed the medication hydrocortisone cream, however; during a subsequent appointment there is no inquiry in the notes regarding the use of the hydrocortisone cream. In Case 3, the PCP did not address the patient's chief complaint in the history, assessment or plan.
- In Cases 1, 4, 8 and 14, the, medical action taken by the provider was not suitable to the diagnosis or the patient's medical complaint. For example, in Case 1, the length of treatment for the hydrocortisone cream was not documented and the plan for follow-up was "as needed" (PRN) and the patient was not scheduled for follow-up for 6 months. In Case 14, the patient was seen after injuring his middle finger; the PCP ordered and x-ray of the finger as a result of decreased range of motion and the inability to make a fist. The PCP did not document the appearance, swelling and tenderness to palpation of the finger.
- In Cases 1, 3 and 14, the provider did not address the patient's chief medical complaint. For example, in Case 14, the patient's chief complaint of cough is not addressed in the assessment and plan of the PCP's progress note. During a separate appointment for a complaint of back pain, the PCP failed to document details of low back pain.
- In Cases 1 and 7, no physician documentation was available in the eUHR.

Quantitative Review Results

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

Access to Care		**Yes**	**No**	**Compliance**
4.1	Does the registered nurse review the CDCR Form 7362, *Health Care Services Request*, or similar form on the day it is received?	23	1	95.8%
4.2	Following the review of the CDCR Form 7362, or similar form, does the registered nurse complete a face-to-face evaluation of a patient within the specified time frame?	24	0	100%
4.3	Does the registered nurse document the patient's chief complaint in the patient's own words?	24	0	100%
4.4	Does the registered nurse document the face-to-face encounter in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format?	24	0	100%
4.5	Is the focused subjective/objective assessment conducted based upon the patient's chief complaint?	16	8	66.7%
4.6	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	21	3	87.5%
4.7	Does the registered nurse implement a plan based upon the documented subjective/objective assessment data that is within the nurse's scope of practice or supported by the nursing sick call protocols?	24	0	100%
4.8	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	5	19	20.8%
4.9	If the registered nurse determines a referral to the primary care provider is necessary, is the patient seen within the specified time frame?	22	2	91.7%
4.10	If the registered nurse determines the patient's health care needs are beyond the level of care available at the facility, does the nurse contact or refer the patient to the hub institution? (MCCF Only)	3	0	100%
4.11	If the patient presented to sick call three or more time for the same medical complaint, does the registered nurse refer the patient to the primary care provider?	3	0	100%
4.12	Does nursing staff conduct daily rounds in segregated housing units? (COCF only)	Not Applicable		
4.13	Does nursing staff conduct daily rounds in segregated housing units to collect CDCR Forms 7362, *Health Care Services Request*, or similar forms? (COCF only)	Not Applicable		
4.14	Are CDCR Forms 7362, *Health Care Services Request*, or similar forms readily accessible to patients in all housing units?	8	0	100%
4.15	Are patients in all housing units able to submit the CDCR Forms 7362, *Health Care Services Request*, or similar forms on a daily basis?	8	0	100%
	Overall Quantitative Review Score:			**89.4%**

Comments:

For questions 4.1 through 4.11, a random sample of 24 patient medical records were reviewed for the audit review period of October 2015 through March 2016.

1. Question 4.1 – Twenty-three medical records contained documentation that the RN reviewed the CDCR Form 7362, *Health Care Services Request,* on the day it was received. One record contained documentation that the 7362 was not reviewed the same day it was received. This equates to 95.8% compliance.
2. Question 4.5 – Sixteen medical records contained documentation that the RN completed a focused subjective/objective assessment on the patient based upon the patient's chief complaint and eight had no documentation that a focused subjective/objective assessment was completed. This equates to 66.7% compliance.
3. Question 4.6 – Twenty-one medical records contained documentation that the RN documented a nursing diagnosis related to/evidenced by the subjective/objective assessment data; three records did not reflect documentation of a nursing diagnosis. This equates to 87.5% compliance.
4. Question 4.8 – Five medical records contained documentation reflecting the RN documented effective communication was established and that education was provided to the patient, relating to the treatment plan. Nineteen medical records contained no documentation reflecting the establishment of effective communication or that education was provided. This equates to 20.8%% compliance.
5. Question 4.9 – Twenty-two medical records contained documentation that if an RN determined a referral to the PCP was necessary, the patient was seen within the specified time frame. Of the two records that were found non complaint; one did not contain documentation that the patient was seen by the PCP in an urgent manner and the other patient's medical record did not have documentation to support that a referral was made to the PCP. This equates to 91.7% compliance.
6. Questions 4.12 and 4.13 – Not applicable. These questions pertain to the patient population housed in out-of-state facilities only.

5. CHRONIC CARE MANAGEMENT

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
63.3% [*Inadequate*]
Overall Rating:
Adequate

The case review for C*hronic Care Management* received an *adequate* rating while the quantitative review resulted in an inadequate rating. The CCHCS clinicians determined that the overall rating for *Chronic Care Management* indicator is *adequate.* During the quantitative review, the facility failed to document on the CDCR Form 7225, *Refusal of Examination and/or Treatment*, when the patient refused his keep-on-person medications.

Case Review Results

The CCHCS clinician reviewed 25 encounters related to *Chronic Care Management*; 17 provider encounters and 8 nursing encounters. Out of the 25 encounters, 6 deficiencies were found in this indicator; five in provider care and one in nursing care.

In the nursing case review (Case 7) deficiency, the PCP had ordered nursing staff to monitor the patient's blood pressure monthly for six months; however, there is no documentation in the eUHR supporting that nursing staff followed the physician's order and monitored his blood pressure monthly.

The provider deficiencies identified were:

- In Cases 8, the PCP did not follow-up on the patient's blood sugar levels to verify how the twice daily Metformin is impacting the patient's glucose levels and to determine if the patient was having any side effects to the medication.

- In Case 2, patient was seen for Gastroesophageal Reflux Disease (GERD). The PCP added a prescription for TUMS but did not address the patient's use of Nonsteroidal Anti-inflammatory Drugs (NSAIDs) and the possibility of discontinuing their use. The PCP failed to discuss and recommend lifestyle and diet modifications for GERD management.

- In Cases 2, 13 and 15, the PCP failed to thoroughly document all patients Chronic Care appointments. In Case 2, the patient is prescribed Prilosec for his GERD as well as prescribed Vitamin D, however the PCP does not address the rationale for the Vitamin D nor did the PCP address that the patient's chronic Ibuprofen use. In case 13, the patient suffers from severe knee pain; the PCP documented that the patient has decreased range of motion, however, does not notate the patient's gait. In Case 15, the PCP ordered a urine microalbumin laboratory test but did not document the rationale for the order as the patient was not diabetic and was not diagnosed with a metabolic syndrome.

Quantitative Review Results

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

Chronic Care Management		**Yes**	**No**	**Compliance**
5.1	Is the patient's chronic care follow-up visit completed as ordered?	27	3	90.0%
5.2	Are the patient's chronic care medications received by the patient without interruption within the required time frame?	28	0	100%
5.3	If a patient refuses his/her chronic care keep-on-person medications, is the refusal documented on the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form?	0	1	0.0%
5.4	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient referred to a primary care provider?	Not Applicable		

5.5	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient seen by a primary care provider within seven calendar days of the referral?	Not Applicable
5.6	If a patient does not show or refuses his/her insulin, is the patient referred to a primary care provider for medication non-compliance?	Not Applicable
	Overall Quantitative Review Score:	**63.3%**

Comments:

For questions 5.1 through 5.6, a random sample of 30 patient medical records were reviewed for the audit review period of October 2015 through March 2016.

1. Question 5.1 – Twenty-seven medical records reviewed contained documentation that the patient's chronic care follow-up visit was completed as ordered. Three records contained documentation that the patients chronic care appointments were conducted after their scheduled dates. This equates to 90.0% compliance.
2. Question 5.3 – Twenty-nine of the records reviewed within the selected sample did not meet the criteria for this question. The one applicable record did not contain documentation that the patient signed the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form when he refused his chronic care keep-on-person medications. This equates to 0.0% compliance.
3. Questions 5.4 and 5.5 – Not applicable. There were no instances of any patient not showing or refusing the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week during the audit review period. Therefore these questions could not be evaluated.
4. Question 5.6 – Not applicable. None of the patients within the selected sample met the criteria for this question; therefore, compliance with this requirement could not be evaluated at this time.

6. COMMUNITY HOSPITAL DISCHARGE

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
Not Applicable
Overall Rating:
Not Applicable

During the audit review period of October 2015 through March 2016 there were two patients who were sent to a community hospital emergency department (ED) for a higher level of care. Both cases did not warrant an admission and the two patients were returned to the hub institution and/or MCCF on the same day. As a result of these two patients not being admitted to the hospital, this chapter could not be rated by the auditors and is deemed not applicable. However, these two cases are rated under Chapter 12 – *Specialty Services.*

7. DIAGNOSTIC SERVICES

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
95.6% [*Proficient*]
Overall Rating:
Adequate

GSMCCF did very well in the *Diagnostic Services* indicator. Although compliance in the Quantitative review was proficient, the clinical case reviews rated adequate. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on the patient's health care condition. CCHCS clinicians determined that GSMCCF's overall performance in *Diagnostic Services* indicator to be *adequate.*

Case Review Results

The CCHCS auditors reviewed a total of 17 encounters related to Diagnostic Services, 10 of which were nursing encounters and seven provider encounters. Of the 17 encounters, 3 deficiencies were identified; one nursing and two physician.

In the nursing case review (Case 4) deficiency, the PCP had ordered nursing staff to collect a urinalysis on the patient on January 6, 2016, however the specimen was not collected until February 10, 2016. Routine diagnostic tests should be completed within 14 days of order.

The two physician deficiencies identified during the case review are as follows:

- In Case 3, the patient requested that the PCP order HIV, HCV, and DM screening. The PCP ordered a Hepatitis (HEP) A and Hepatitis B labs, Chem 14 and lipid panel. These unnecessary labs can lead to false positive results and unnecessary diagnostic workups.
- In Case 12 the PCP ordered a HEP A, B, C panel, alanine aminotransferase (ALT), aspartate aminotransferase (AST) and gamma-glutamyl transferase (GGT) labs; all of which the PCP provided no rationale as to why the labs were ordered.

Quantitative Review Results

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

Diagnostic Services		Yes	No	Compliance
7.1	Is the diagnostic test completed within the time frame specified by the primary care provider?	18	0	100%
7.2	Does the primary care provider review, sign, and date all patients' diagnostic test report(s) within two business days of receipt of results?	18	0	100%
7.3	Is the patient given written notification of the diagnostic test results within two business days of receipt of results?	18	0	100%
7.4	Is the patient seen by the primary care provider for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results?	14	3	82.4%
		Overall Quantitative Review Score:		**95.6%**

Comments:

For questions 7.1 through 7.4, a random sample of 18 patient medical records were reviewed for the audit review period of October 2015 through March 2016.

1. Question 7.4 – One of the 18 cases reviewed was found not applicable to this question as the patient did not require a follow-up appointment for his slightly lower than normal HDL cholesterol results and could wait until his chronic care appointment. Fourteen patient medical records included documentation that the patient was seen by the provider for clinically significant/abnormal diagnostic test results within 14 days and three were found non-compliant with this requirement. Two patients with abnormal tests results were not seen by the PCP until one month later and one patient's medical record did not document a follow-up visit with the PCP. This equates to 82.4% compliance.

8. EMERGENCY SERVICES

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

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
Not Applicable
Overall Rating:
Adequate

Case Review Results

The findings of the clinical case reviews report the facility preformed adequately as it relates to the *Emergency Services* indicator. Overall, the CCHCS clinicians found that the quality of the physician and the nursing care in emergency services was *adequate.*

During the audit review period there were limited cases where patients were transferred to the community hospital emergency department for a higher level of care. The CCHCS clinicians reviewed a total of four encounters; three nursing and one physician encounters related to *Emergency Services* and found no deficiencies.

9. HEALTH APPRAISAL/HEALTH CARE TRANSFER

This indicator determines whether the facility adequately manages patients' medical needs and continuity of patient care during inter- and intra-facility transfers by reviewing the facility's ability to timely: perform initial health screenings, complete required health screening assessment documentation (including tuberculin screening tests), and deliver medications to patients received from another facility. Also, for those patients who transfer out of the facility, this indicator reviews the facility's ability to document transfer information that includes pre-existing health conditions, pending specialty and chronic care appointments, medication transfer packages, and medication administration prior to transfer.

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
80.9% [*Inadequate*]
Overall Rating:
Inadequate

The facility performed insufficiently in the quantitative and clinical case review sections. The deficiencies were mainly due to incomplete nursing documentation and failing to complete health appraisals in the required time frames. Based on the clinical case review and quantitative findings, GSMCCF received an *inadequate* rating in the *Health Appraisal/Health Care Transfer* indicator.

Case Review Results

The CCHCS clinicians reviewed a total of 17 encounters related to *Health Appraisal/Health Care Transfer* and found 8 deficiencies of which all were related to nursing performance. No deficiencies were found with the provider's performance. The CCHCS nurse auditor reviewed a total of 15 nursing encounters related to Health Care Appraisal/Health Care Transfer services. The nursing deficiencies identified were:

- TB symptom screenings were not completed upon the patient's arrival at GSMCCF (Cases 11 and 12).
- The *Health care Transfer Information* Form (CDCR 7317) was not signed by the GSMCCF nurse to indicate she reviewed the information on the form (Cases 8 and 13).
- The *Initial Health Screening* form CDCR 7277 was not completed by nursing staff, instead the nursing documentation was done on the nurses progress note (Case 12).
- The *Health care Transfer Information* Form (CDCR 7317) was not completed prior to patient being transferred out of facility (Case 15).

It is crucial that nursing staff who complete the *Initial Health Screening* form CDCR 7277 for newly arrived patients and/or the *Health care Transfer Information* forms (CDCR 7317) for patients transferring out, to adequately answer and complete all forms to include a detailed response for each question. This will help the facility to improve in this area in subsequent audits.

Quantitative Review Results

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

Health Appraisal/Health Care Transfer		**Yes**	**No**	**Compliance**
9.1	Does the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	12	6	66.7%
9.2	If "YES" is answered to any of the medical problems on the *Initial Health Screening* form (CDCR 7277/7277A or similar form), does the registered nurse document an assessment of the patient?	7	0	100%
9.3	If a patient presents with emergent or urgent symptoms during the initial health screening, does the registered nurse refer the patient to the appropriate provider?	Not Applicable		
9.4	If a patient is not enrolled in the chronic care program but during the initial health screening was identified as having a chronic disease/illness, does the registered nurse refer the patient to the primary care provider to be seen within the required time frame??	Not Applicable		
9.5	If a patient was referred to an appropriate provider during the initial health screening, was the patient seen within the required time frame?	Not Applicable		
9.6	If a patient was enrolled in a chronic care program at a previous facility, is the patient scheduled and seen by the receiving facility's primary care provider within the time frame ordered by the sending facility's chronic care provider?	6	0	100%
9.7	If a patient was referred by the sending facility's provider for a medical, dental, or a mental health appointment, is the patient seen within the time frame specified by the provider?	Not Applicable		
9.8	Does the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	11	6	64.7%
9.9	Does the patient receive a complete health appraisal within seven calendar days of arrival?	15	2	88.2%
9.10	If a patient had an existing medication order upon arrival at the facility, were the nurse administered medications administered without interruption and keep-on-person medications received within one calendar day of arrival?	4	0	100%
9.11	When a patient transfers out of the facility, are the scheduled specialty services appointments that were not completed, documented on a Health Care Transfer Information Form (CDCR 7371) or a similar form?	5	13	27.8%
9.12	Does the Inter-Facility Transfer Envelope contain all the patient's medications, current Medication Administration Record and Medication Profile?	2	0	100%
	Overall Quantitative Review Score:			**80.9%**

Comments:

For questions 9.1 through 9.11, a random sample of 18 patient medical records were reviewed for the audit review period of October 2015 through March 2016.

1. Question 9.1 – Twelve patient medical records reviewed included documentation that the patient received an initial health screening upon arrival at the facility and six records were found non-compliant with this requirement. This equates to 66.7% compliance.
2. Question 9.3 – Not Applicable. None of the 18 medical records reviewed showed the patient presented with emergent or urgent symptoms during the initial health screening and therefore did not require the RN to refer the patient to the appropriate provider. Therefore, this question could not be evaluated.
3. Question 9.4 – Not Applicable. Six of the medical records reviewed showed the patient was already enrolled in the chronic care program. There was no documentation contained in the remaining 12 medical records to show those patients were identified during the initial health care screening as having a chronic disease/illness; thereby not requiring the RN to refer the patient to the PCP to be seen. Therefore, this question could not be evaluated.
4. Question 9.5 – Not Applicable. None of the 18 medical records reviewed showed the patient required a referral to the PCP during the initial health screening. Therefore, this question could not be evaluated.
5. Question 9.7 – Not Applicable. None of the 18 medical records reviewed showed the patient was referred by the sending facility's PCP for a medical, mental, or dental appointment. Therefore, this question could not be evaluated.
6. Question 9.8 – Of the 18 medical records reviewed, 1 was deemed not applicable as the patient was transferred back to the hub facility and was housed less than 24 hours at GSMCCF. Eleven medical records reviewed contained documentation that the patient received a complete screening for the signs and symptoms of tuberculosis upon arrival at GSMCCF; six medical records did not contain documentation the patient received the TB screening. This equates to 64.7% compliance.
7. Question 9.9 – Of the 18 medical records reviewed, 1 record was deemed not applicable as the patient was transferred back to the hub facility and was housed less than 24 hours at GSMCCF. Of the remaining 17 records, 15 records contained documentation that the patient received a complete health appraisal (H&P) within 7 calendar days of his arrival at GSMCCF. One appraisal was completed 12 days after arrival and in one record the health appraisal was not completed until nine days after the patient's arrival. This equates to 88.2% compliance.
8. Question 9.11 – Eighteen medical records were reviewed for patients who transferred out of the facility within the audit review period. Five records contained documentation that when the patient was transferred out of the facility and there were scheduled specialty services appointments that had not been accomplished, the appointment information was documented on a *Health care Transfer Information* Form (CDCR 7317); thirteen records did not contain the 7371 form. This equates to 27.8% compliance.

10. MEDICATION MANAGEMENT

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
95.1% [*Proficient*]
Overall Rating:
Proficient

The case review for Medication *Management* received an *adequate* rating while the quantitative review resulted in a proficient rating. The quantitative review resulted in an overall score of 95.1%, equating to a quality indicator of *proficient,* while the case review resulted in an *adequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the critical nature of the deficiencies identified during case reviews and their potential impact on patients' health care condition. The case reviews resulted in minimal deficiencies and were minor in nature and did not significantly impact on the care provided to the patients. Therefore, the CCHCS clinicians determined the appropriate overall rating for this indicator as *proficient.*

Case Review Results

The CCHCS clinicians reviewed a total of 118 encounters related to medication management and found 8 deficiencies, 7 in nursing performance and 1 in provider's performance. Fifty-seven percent (4) of the nursing deficiencies involved the patients not receiving their medication in a timely manner. The seven deficiencies were identified with nursing performance is as follows:

- In Cases 1 and 2 on several occasions, there was a delay in administering the prescribed medication to the patient.
- In Cases 2, 4 and 6 there is no documentation in the eUHR supporting that the patients received their medications.
- In Case 7 nursing staff did not check the frequency of dispensing the Hydrochlorothiazide to the patient. Patient was dispensed his first 30 day supply on March 3, 2016 and then reissued another 30 day supply on March 8, 2016.

The provider deficiency identified is as follows:

- In Case 3 the PCP started the patient on a four week course of antibiotic (amoxicillin) after a sinus x-ray despite significant improvement after taking allergy medication. It is not necessary to treat x-ray reading if the patient is clinically better. Antibiotic resistance and side effects should be considered whenever prescribing antibiotics and PCP should consider treating symptoms and observing the patient without initiating antibiotics if the patient is significantly improved.

Quantitative Review Results

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

Medication Management		**Yes**	**No**	**Compliance**
10.1	Does the prescribing primary care provider document that the patient was provided education on the newly prescribed medications?	17	1	94.4%
10.2	Is the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	17	1	94.4%
10.3	Does the nursing staff confirm the identity of a patient prior to the delivery and/or administration of medications?	2	0	100%
10.4	Does the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	1	0	100%
10.5	Does the medication nurse directly observe a patient taking direct observation therapy medication?	1	0	100%
10.6	Does the medication nurse document the administration of nurse administered/direct observation therapy medications on the Medication Administration Record once the medication is given to the patient?	1	0	100%
10.7	Are medication errors documented on the Medication Error Report form?	2	1	66.7%
10.8	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food and/or laboratory specimens?	1	0	100%
10.9	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	60	0	100%
10.10	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas?	Not Applicable		
10.11	Are the narcotics inventoried at the beginning and end of each shift by licensed health care staff?	Not Applicable		
10.12	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers and/or nitroglycerine tablets? (COCF only)	Not Applicable		
	Overall Quantitative Review Score:	**95.1%**		

Comments:

For questions 10.1 and 10.2, a random sample of 18 patient medical records were reviewed for the audit review period of October 2015 through March 2016.

1. Question 10.1 – Seventeen medical records were reviewed that contained documentation of the PCP providing education on the newly prescribed medications to the patient; one medical record did not have documentation citing that the PCP provided education on newly prescribed medications. This equates to 94.4% compliance.
2. Question 10.2 – Seventeen medical records were reviewed containing documentation that the initial dose of the newly prescribed medication was administered to the patient as ordered by the provider; one medical record staff failed document that a newly prescribed medication was administered as ordered by the PCP. This equates to 94.4% compliance.

3. Question 10.7 – During the onsite audit two RN's and a Licensed Vocational nurse (LVN) were interviewed on the medication error process, the two RN's could thoroughly describe GSMCCF's medication error process. The LVN was not familiar with the medication error reporting policy. This equates to 66.7% compliance.
4. Questions 10.10 and 10.11 – Not Applicable. GSMCCF does not store narcotic medications at the facility.
5. Question 10.12 – Not Applicable. The Modified Community Correctional Facilities do not have an administrative segregation unit; therefore this question was not evaluated.

11. OBSERVATION CELLS

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

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
Not Applicable,

Overall Rating:
Not Applicable

12. SPECIALTY SERVICES

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

The case review and quantitative review process resulted in similar findings. Both reviews resulted in an overall *inadequate* rating for this indicator.

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
64.6% [Inadequate]

Overall Rating:
Inadequate

Case Review Results

The CCHCS auditors reviewed a total of 22 encounters related to *Specialty Services* and found 8 deficiencies. Six deficiencies were related to nursing performance and two were related to provider performance. The nursing deficiencies identified were:

- In Cases 4, 5, 6, and 8, the nursing staff failed to conduct an assessment of the patient prior to sending the patient out of the facility.
- In Case 10, the nursing staff did not document any notes or complete a *Health care Transfer Information* Form (CDCR 7317) prior to transferring the patient out for specialty services and transfer.

The provider deficiencies identified were:

- In Cases 8 and 13, the physician made unnecessary referrals for specialty services. In case 8, patient was referred for an echocardiogram regarding his sinus bradycardia and left ventricular hypertrophy (LVH). In case 13, patient was referred for a liver biopsy even though a Fibroscan was completed. A liver biopsy was not indicated for this patient.

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

Quantitative Review Results

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

Specialty Services		**Yes**	**No**	**Compliance**
12.1	Is the primary care provider's request for specialty services approved or denied within the specified time frame? (COCF Only)	Not Applicable		
12.2	Is the patient seen by the specialist for a specialty services referral within the specified time frame? (COCF Only)	Not Applicable		
12.3	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	13	3	81.3%
12.4	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse notify the primary care provider of any immediate orders or follow-up instructions provided by the hub, a specialty consultant, or emergency department physician?	1	3	25.0%
12.5	Does the primary care provider review the specialty consultant's report, hub provider's report or the community emergency department provider's discharge summary and complete a follow-up appointment with the patient within the required time frame?	14	2	87.5%
	Overall Quantitative Review Score:			**64.6%**

Comments:

For questions 12.3 through 12.5, a random sample of 16 patient medical records were reviewed for the audit review period of October 2015 through March 2016.

1. Questions 12.1 and 12.2 – Not applicable. These questions do not apply to in-state correctional facilities.
2. Question 12.3 – Thirteen patient medical records included documentation of the RN completing a FTF assessment prior to the patient's return to the assigned housing unit. All three non-compliant records

were missing documentation of RN's FTF assessment on the patients return. This equates to 81.3% compliance.

3. Question 12.4 – Twelve medical records reviewed were not applicable as there were no immediate orders or follow-up instructions for these patients. Of the four applicable records, three records nursing staff failed to document that the RN reviewed the specialty encounter. This equates to 25.0% compliance.

4. Question 12.5 – Fourteen patient medical records contained documentation that the PCP reviewed the specialty consultant's report, hub provider's report or community ED provider's discharge summary and completed a follow-up appointment with the patient within the required time frame. The two non-compliant records showed no documentation that the PCP completed a follow-up appointment with the patient within the required time frame. This equates to 87.5% compliance.

13. PREVENTIVE SERVICES

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

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

For *Preventative Services* indicator, the quantitative review findings resulted in a *proficient* rating. The overall indicator rating is determined to be *proficient.*

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
100% [*Proficient]*

Overall Rating:
Proficient

Quantitative Review Results

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

Preventive Services		Yes	No	Compliance
13.1	*For patients prescribed anti-Tuberculosis medication(s):* Does the facility administer the medication(s) to the patient as prescribed?	7	0	100%
13.2	*For patients prescribed anti-Tuberculosis medication(s):* Does the nursing staff notify the primary care provider or a public health nurse when the patient misses or refuses anti-TB medication?	Not Applicable		
13.3	*For patients prescribed anti-Tuberculosis medication(s):* Does the facility monitor the patient monthly while he/she is on the medication(s)?	7	0	100%
13.4	Do patients receive a Tuberculin Skin Test annually?	Not Applicable		

13.5	Are the patients screened annually for signs and symptoms of tuberculosis?		Not Applicable	
13.6	*For all patients:* Were the patients offered an influenza vaccination for the most recent influenza season?	20	0	100%
13.7	*For all patients 50 to 75 years of age:* Are the patients offered colorectal cancer screening?	7	0	100%
13.8	*For female patients 50 to 74 years of age:* Is the patient offered a mammography at least every two years?		Not Applicable	
13.9	*For female patients 21 to 65 years of age:* Is the patient offered a Papanicolaou test at least every three years?		Not Applicable	
	Overall Quantitative Review Score:			**100%**

Comments:

1. Question 13.2 – Not Applicable. During the audit review period of October 2015 through March 2016 there were three patients on TB medication. None of the patients' missed or refused any of their anti TB medications, therefore this question could not be evaluated.
2. Questions 13.4 and 13.5 – Per the methodology, these questions are evaluated once per calendar year and during the audit review period when the annual TB testing occurs per the master calendar on Lifeline. As the audit review period for GSMCCF's current audit did not encompass the month when the facility provided annual TB testing and screening to its CDCR patient population, these questions could not be evaluated for compliance with this requirement.
3. Questions 13.8 and 13.9 – Not applicable. These questions only apply to correctional facilities housing female patient population.

14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
80.8% [*Inadequate*]
Overall Rating:
Inadequate

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

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

The facility received an *inadequate* rating with a score of 80.8% in the *Emergency Medical Response/Drills& Equipment* indicator. The facility's one Emergency Medical Response (EMR) Bag was out of compliance. The facility's EMR bag contained unapproved items (forceps and a pediatric oral airway tube) and emergency medications in the bag; such as Benadryl, Narcan, Epinephrine and

Nitrostat. These emergency medications are essential in life-saving situations however, are not a requirement for the MCCF's. According to the HSA the medications are supplied by the hub facility. The auditors made the recommendation to remove these medications from the EMR bag and place them in a separate locked box in the clinician's office.

For three out of the six months of the EMMRC meeting minutes; there were no nursing notes or CPR records submitted with the scenarios requiring CPR or nursing notes. The HSA inquired as to the rationale for these documents as she did not understand why the documents were needed; the auditor referred her to the IMSP&P, which states which documents are required to be completed for actual emergency medical responses.

Additionally, GSMCCF is not in compliance with the monthly inventory of the EMR bag, when it has not been used during emergency medical responses and/or drills. Based on the logs provided to the auditors, the facility inventoried the EMR bags once in the six month period, as opposed to once per month as required. The auditors also discussed the need to open and reseal the EMR bag when used for emergency drills that would warrant the opening of the bag in an actual emergency. This is a requirement of IMSP&P.

Quantitative Review Results

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

Emergency Medical Response/Drills & Equipment		**Yes**	**No**	**Compliance**
14.1	Does the facility conduct emergency medical response drills quarterly on each shift when medical staff is present?	6	0	100%
14.2	Does a Basic Life Support certified health care staff respond without delay after emergency medical alarm is sounded during an emergency medical response (man-down) and/or drill?	9	0	100%
14.3	Does a registered nurse or a primary care provider respond within eight minutes after emergency medical alarm is sounded for an emergency medical response (man-down) and/or drill?	9	0	100%
14.4	Does the facility hold an Emergency Medical Response Review Committee a minimum of once per month?	6	0	100%
14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	3	3	50.0%
14.6	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	90	0	100%
14.7	If the emergency medical response and/or drill warrant an opening of the Emergency Medical Response Bag, is the bag re-supplied and re-sealed before the end of the shift?	1	0	100%
14.8	If the emergency medical response bag has not been used for emergency medical response and/or drill, is it being inventoried at least once a month?	0	5	0.0%
14.9	Does the facility's Emergency Medical Response Bag contain only the supplies identified on the Emergency Medical Response Bag Checklist in compliance with Inmate Medical Services Policies and Procedures requirements?	0	1	0.0%
14.10	Is the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	Not Applicable		

14.11	If the emergency medical response and/or drill warrant an opening and use of the medical emergency crash cart, is the crash cart re-supplied and re-sealed before the end of the shift? (COCF Only)	Not Applicable		
14.12	If the medical emergency crash cart has not been used for a medical emergency and/or drill, was it inventoried at least once a month? (COCF Only)	Not Applicable		
14.13	Does the facility's crash cart contain all the medications as required/approved per *Inmate Medical Services Policies and Procedures*? (COCF Only)	Not Applicable		
14.14	Does the facility's crash cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	Not Applicable		
14.15	Does the facility have a functional Automated External Defibrillator with electrode pads located in the medical clinic?	1	0	100%
14.16	Does the facility have a functional 12-lead electrocardiogram machine with electrode pads? (COCF Only)	1	0	100%
14.17	Does the facility have a functional portable suction device?	1	0	100%
14.18	Does the facility have a portable oxygen system that is operational ready?	1	0	100%
	Overall Quantitative Review Score:			**80.8%**

Comments:

1. Question 14.5 – The compliance rating for this question was based on the EMRRC meetings conducted during the audit review period of October 2015 through March 2016. Although the meetings were held every month; the incident packages submitted for the EMRRC's review for the months of December, January and February lacked the required documents (Form 7462 and Form 7463). This equates to 50.0% compliance.

2. Question 14.8 – For the months of October 2015 through February 2016, the facility did not inventory the EMR bags. GSMCCF staff inventoried the EMR bag only in the month of March 2016, which is reflected in question 14.7. This equates to 0.0% compliance.

3. Question 14.9 – The EMR bag contained unapproved supplies (forceps and a pediatric oral airway tube) not listed on the EMR bag checklist. Additionally, the EMR bag included emergency medications such as Benadryl, Narcan, Epinephrine, and Nitrostat, which are essential in lifesaving measures. However, the EMR should not contain these medications and should be placed in a separate locked box in the medical clinic. This equates to 0.0% compliance.

4. Questions 14.10 through 14.14 – Not applicable. These questions do not apply to in-state correctional facilities as they do not maintain a medical emergency crash cart.

15. CLINICAL ENVIRONMENT

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
99.3% [*Proficient*
Overall Rating:
Proficient

The facility received a *proficient* rating with a score of 99.3% in the Clinical Environment indicator. The one deficiency found for this indicator was the facility's portable suction device was not calibrated and did not have a sticker placed on it showing that that it had been serviced.

Quantitative Review Results

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

Clinical Environment		Yes	No	Compliance
15.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	27	0	100%
15.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	1	0	100%
15.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	2	0	100%
15.4	Does clinical health care staff adhere to universal hand hygiene precautions?	2	0	100%
15.5	Is personal protective equipment readily accessible for clinical staff use?	1	0	100%
15.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	2	0	100%
15.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	1	0	100%
15.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	30	0	100%
15.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	3	0	100%
15.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	2	0	100%
15.11	Are sharps/needles disposed of in a puncture resistant, leak-proof container that is closeable, locked, and labeled with a biohazard symbol?	2	0	100%
15.12	Does the facility store all sharps/needles in a secure location?	1	0	100%

15.13	Does the health care staff account for and reconcile all sharps at the beginning and end of each shift?	90	0	100%
15.14	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	1	0	100%
15.15	Is the facility's biomedical equipment serviced and calibrated annually?	7	1	87.5%
15.16	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	1	0	100%
15.17	Does the clinic visit location ensure the patient's visual and auditory privacy?	1	0	100%
	Overall Quantitative Review Score:			**99.3%**

Comments:

- Question 15.15 – While onsite; eight pieces of biomedical equipment were inspected to validate the equipment had annual service/calibrations conducted. The portable suction device did not have a service sticker indicating that the equipment had not been calibrated. This equates to 87.5% compliance.

16. QUALITY OF NURSING PERFORMANCE

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The Quality of Nursing Performance at GSMCCF was rated *adequate*. This justification was determined through conducting a thorough review of 10 patient's medical records, who were housed at GSMCCF during the audit review period. There were two cases (Cases 3 and 9) found to be *proficient* during the nursing case review and therefore are not documented below. Of the remaining eight cases; six were found to be *adequate* and two *inadequate.* Of the 236 total nursing encounters/visits assessed within the 10 detailed case reviews, 30 deficiencies were identified related to nursing care and nursing performance. The vast majority of the deficiencies involve both nursing assessment and documentation, inter and intra facility transfer processes and medication management process. The nursing services found to be inadequate/deficient at GSMCCF include:

- Failure to review CDCR Form 7362, *Health Care Services Request* within one day of receipt as identified in *IMSP&P* (identified in Cases 1, 4 and 5).
- Delays in administration of ordered medication (identified in Cases 1 and 2).
- Inadequate assessments of patients prior to sending to specialty care appointments (identified in Cases 5, 6, 8 and 10).

- Failure of facility nurses to countersign the Health Care Transfer Information form to indicate they had reviewed the information (identified in Cases 8, and 13).
- Failure to follow the PCP orders when prescribed (identified in Cases 4 and 7).
- Failure to provide a thorough assessment of the patient related to the patient's medical complaint during the sick call process (identified in Cases 1, 6 and 8)

Case Number	Deficiencies
Case 1	***Adequate.*** A thirty-three year old patient with no chronic illnesses. During the audit review period the patient had been afflicted with acne vulgaris and was prescribed Benzoyl Peroxide. The patient had also submitted sick call requests for optometry and dental services. The nursing deficiencies in this case were due to nursing staff not reviewing the sick call requests in a timely manner, not performing a through focused nursing assessment related to the patient's chief medical complaint and not ensuring that the patient received his Keep-on-Person (KOP) medications in a timely manner.
Case 2	***Adequate.*** A forty-eight year old patient with chronic disease of Hypertension (HTN), Gastro esophageal Reflux Disease (GERD) and mild Benign Prostatic Hyperplasia (BPH) nocturia. The audit review period of October 2015 through March 2016 was characterized by frequent patient requests for medication refills of Omeprazole, Amlodipine, Calcium Carbonate, Hydrochlorothiazide and Ibuprofen. During the audit review period the patient had some abnormal cholesterol and Vitamin D results and tooth pain, however the patient's condition was well managed. The nursing deficiencies in this case were due to nursing staff not consistently ensuring that the patients KOP medications were refilled in a timely manner. Also, the lack of documentation in the eUHR to indicate the PCP's order for antacid 500 mg was carried out. Although the patient has a pre-existing order of Omeprazole 20 mg, the ordered dosage is 500 mg and supersedes the pre-existing order of 20 mg.
Case 4	***Inadequate.*** A forty-six year old patient with complaints of acute sinusitis, scalp folliculitis, and BPH with nocturia. During the audit review period the patient complained of poor vision, for which he was referred to an offsite optometrist. The patient also complained of frequent nocturia, itching and a rash on his scalp area. This case was deemed inadequate for the following reasons. ▪ Nursing staff did not correctly state the nursing diagnosis of the patient's chief complaint. Patient complained of having problems with eyesight; subsequently, nursing staff documented that the patient's chief complaint was Health Maintenance of his right eyesight. ▪ The RN did not review sick call slips in a timely manner. ▪ Physician lab orders were not carried out by nursing staff in a timely manner. Physician ordered urinalysis on January 6, 2016, and the specimen was not collected by nursing staff until February 10, 2016. Routine diagnostic tests should be collected within 14 days of the order. ▪ The RN did not conduct an assessment of the patient prior to sending the patient out for his specialty care appointment nor was a nursing assessment conducted when patient returned from the specialty care appointment. ▪ Nursing staff did not administer patients KOP medications as ordered. PCP ordered the patient to start Actifed, Tesselon, Perles and Cepacol on March 21, 2016. The KOP Medication Administration Record (MAR) did not document that the patient received his Actifed.
Case 5	***Adequate.*** A fifty-five year old patient with diagnoses of lichen scleroses at the perianal area. During the audit review period, the patient complained of upper respiratory infection and

	scapular pain due to intense workouts (push-ups). The patient was sent to the hub institution for a specialty optometry referral. The nursing deficiencies in this case are a result of unsuccessfully reviewing sick call requests in a timely manner and not conducting a thorough nursing assessment of the patient when patient was sent to his specialty care appointment. Specifically nursing staff did not perform an objective assessment of the patient's chief complaint or take his vitals prior to sending him to his offsite appointment.
Case 6	***Adequate.*** A forty-seven year old patient with chronic diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and hyperlipidemia. During the audit review period, the patient had been afflicted with dry, itchy eyes, sore throat, nasal congestion, and one episode of falling. The patient was referred to optometry for eyeglasses, which he received. During the audit review period, the patient submitted several sick call requests; most of the requests were submitted for medication refills. The deficiencies identified in this case are as a result of the nursing staff's failure to conduct a thorough assessment of the patient prior to his transfer to the hub institution for his optometry appointment, failure to conduct an objective focused assessment related to the patient's chief complaint and failure to document a proper nursing diagnosis.
Case 7	***Adequate.*** A sixty-two year old patient with chronic diagnoses of hypertension, diabetes, GERD, hyperlipidemia and hypothyroidism. During the audit review period the patient was seen for his chronic care conditions; during these visits the patient complained of dry cough, heart burn and acid reflux. Nursing staff were tasked with monitoring the patient's blood pressure (BP), blood sugar levels and refilling the patient's KOP medications. The patient's triglycerides and hemoglobin A1C levels remain above the normal range during the audit review period. This case consisted of two deficiencies: ▪ Nursing staff failed to check the patient's utilization of medications which were being dispensed. The patient received a 30 day supply of Hydrochlorothiazide (HCTZ) on March 3, 2016 and nursing staff dispensed another 30 day supply of the same medication on March 8, 2016. ▪ Per the PCP's orders, nursing staff were required to conduct monthly BP checks; however documentation of BP checks was not available in the eUHR.
Case 8	***Inadequate.*** A forty-two year old patient with chronic diagnoses of hypertension, diabetes mellitus, asthma, and seizures. During the audit review period, the patient was afflicted with left lower extremity cellulitis necessitating a transfer to the hub institution's Triage and Treatment area (TTA) for intravenous and oral antibiotic treatment. After the cellulitis resolved, the patient returned to GSMCCF after having been housed at the hub for one month. The patient also complained of chronic low back pain and tinea pedis during his initial intake at GSMCCF. This case was deemed inadequate for the following reasons: ▪ On two occasions nursing staff did not countersign the CDCR Form 7277, *Initial Health Screening*, when the patient arrived at the facility. The first time was when the patient initially arrived at GSMCCF on December 8, 2015, and the second time was when returned to GSMCCF on February 4, 2016 following a medical treatment at the hub facility. The nursing staff are required to countersign CDCR form 7277 to indicate they reviewed all the pertinent medical information on the patient that was received from the sending facility. ▪ Nursing staff did not conduct focused assessments of the patient's identified medical problems. ▪ Nursing staff failed to document their assessment of the patient, prior to sending him to the hub facility.
Case 10	***Adequate.*** A forty-two year old patient who was diagnosed with Hepatitis C (HCV) in 1999, had a Fibroscan at the hub institution which indicated that the patient needed treatment for his HCV. Patient was later transferred to the hub to receive treatment for HCV. The deficiencies in this case are a result of nursing staff not completing a CDCR Form 7277, *Initial Health Screening* when

the patient was transferred to NKSP for HCV treatment and nursing staff not taking appropriate action when the patient complained of liver pain; nursing staff provided the patient with acetaminophen, which is detrimental for a patient with HCV, since Acetaminophen is contraindicated for patients with liver disease. However, the patient was administered Acetaminophen only once and the medication was not repeated throughout the course of treatment thereby correcting the problem.

17. QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
Not Applicable
Overall Rating:
Adequate

Case Review Results

Based on the 15 in-depth case reviews completed by the CCHCS clinician, the facility provider performance was rated *adequate.* Of the 15 detailed cases conducted by the CCHCS physician, none were found proficient, 13 were found *adequate* and 2 were *inadequate*. Out of the total 85 physician encounters/visits assessed, 33 deficiencies were identified.

Primary care services are delivered by a single provider, who has been at the facility for two years. The physician auditor spent several hours with the facility's PCP and observed five clinical encounters. The PCP showed adequate interviewing and physical examination skills. He thoroughly discussed diagnoses, treatment plans, and rationale for new medications with the patients. The PCP's care provided at GSMCCF has been determined to be adequate. The PCP is conscientious about following up on test results for patients and in seeking additional advice from the hub institution facility if necessary. The PCP has shown a desire to continuously improve the services he provides to the patients by his utilization of the CCHCS website; http://www.cphcs.ca.gov/ and re-familiarization of the updated IMSP&P.

During the onsite observations the CCHCS physician made recommendations on two scenarios. The PCP was going to reorder a chest x-ray for a patient with a history of latent TB infection who was previously treated with TB medication. The patient had a negative baseline chest x-ray and his medical chart contained a record of the last chest x-ray being administered in 2013. The PCP was told by a non CDCR outside source that he had to repeat chest x-rays every two years for those patients with a positive Purified Protein Derivative (+ PPD) test when obtaining a physical. The CCHCS physician made the recommendation that the PCP should not reorder a chest x-ray for a history of positive TB skin test with negative chest x-ray unless there is a clinical indication to repeat the test. It was recommended to the PCP to refer to the CCHCS website and CDC guidelines on TB screenings. The second scenario revealed that the PCP was ordering new labs, immunizations and imaging for patients scheduled to have an initial health appraisal due to incomplete information on hand. The physician auditor recommended to the

PCP's LVN to pull all pertinent information for the PCP prior to conducting the initial health appraisal this would reduce the need for the PCP to request unnecessary tests.

As stated above the case reviews were deemed adequate, however some of the provider services that were found to be inadequate/deficient include:

- Lack of documentation to support actions taken (Cases 1, 3, 4, 6, 7, 12, 13, 14 and 15)
- Medication prescribed with no documented length of time (Case 1)
- Improvement and education needed for chronic care conditions (Cases 2, 8, and 13)
- Unnecessary diagnostic services ordered (Case 3, 13 and 14)

Case Number	Deficiencies
Case 1	***Adequate.*** A thirty-three year old patient with no chronic illnesses. During the audit review period the patient had been afflicted with acne vulgaris and was prescribed Benzoyl Peroxide for his acne. The patient also complained of a rash on his face and knee pain. Although the care was adequate there were some deficiencies associated with this case. Documentation was sparse with regards to obtaining history and timeline of patient complaints. The documentation of the bottom bunk chrono should be justified with more details on the necessity of the lower bunk. The patient was prescribed hydrocortisone cream for the rash on his face, however; the length of treatment was not documented. At the beginning of this case, GSMCCF's main PCP was temporarily reassigned to another facility (Desert View Modified Community Correctional Facility), as a result many of the deficiencies in this case were associated to the PCP that was covering GSMCCF.
Case 2	***Adequate.*** A forty-nine year old patient with chronic disease of Hypertension (HTN), Gastroesophageal Reflux Disease (GERD) and mild Benign Prostatic Hyperplasia (BPH) nocturia. The deficiencies associated with this case focus on the patients chronic care treatment. The patient is prescribed Prilosec for his gastrointestinal issues and ibuprofen for his low back pain. There is no documentation of discussion of low back pain and the patient's use of ibuprofen during a chronic care visit. It is recommended that the PCP follow-up on the patients BPH symptoms, educate the patient on what foods to avoid and lifestyle change to reduce GERD symptoms and consider reducing the Proton Pump Inhibitor (PPI) use regarding long term mal-absorption of Magnesium and Calcium.
Case 3	***Adequate.*** A thirty-nine year old patient with left maxillary tenderness and nasal congestion, hyperlipidemia, tinea pedis, and right lower quadrant (RLQ) tender abscess. He also has history of seborrheic dermatitis and dry eyes. During the audit review period, he complained of nasal congestion due to sinusitis problem and a fungal infection of his feet. The deficiencies that could were identified in this case are related to medication management and ordering unnecessary labs. The PCP needs to improve on documentation when ordering sinus x-rays with acute symptoms; the patient had improved with allergy medications. Sinus x-rays are not necessary in a patient with acute-one week's duration of sinus symptoms. Before prescribing an antibiotic to the patient, the PCP should consider reviewing the effects of prescribed antibiotics on the patient and the possible side effects of the antibiotics. . The patient was prescribed four weeks of antibiotic for an x-ray reading of sinusitis despite significant improvement with allergy medicine; likely experiencing allergic rhinitis due to response to allergy medications. The PCP should also consider viral rhinosinusitis. When the patient was diagnosed with uncomplicated acute viral rhinosinusitis, the PCP should consider treating the symptoms and monitoring the patient without initiating antibiotics.
Case 4	***Adequate.*** A forty-six year old patient with complaints of acute upper respiratory infection (URI), scalp folliculitis, and newly diagnosed with BPH. The patient was diagnosed with sinusitis, seborrheic dermatitis and BPH. The only provider deficiency is that the PCP did not document the

	timeline of the acute sinusitis symptom. It is recommended that the PCP use caution when treating an URI as URI's are more often viral and can be symptomatically managed.
Case 5	***Adequate.*** A fifty-five year old patient with diagnoses of lichen scleroses at the perianal area, requested for a lower bunk, and had complaints of URI and shoulder pain from workouts during the audit review period. The care provided to the patient was deemed as adequate.
Case 6	***Adequate.*** A forty-two year old patient with chronic intermittent lower back pain (LBP), cellulitis and tinea pedis. This case was deemed adequate with one deficiency. During the sick call process the PCP missed details on the LBP. It is recommended that the PCP detail the back examination such as appearance, gait, deep tendon reflux (DTR) and thrombotic thrombocytopenic purpura (TTP).
Case 7	***Adequate.*** An eighteen year old patient with atypical chest pain and URI. The lack of detailed and thorough documentation in this case resulted in an adequate rating. During the sick call appointments the PCP failed to document a description of the pain the patient was having, the duration of the pain and whether the patient was a prior drug user.
Case 8	***Adequate.*** A forty-three year old patient with newly diagnosed Diabetes mellitus (DM) as well as hyperlipidemia and bradycardia. The PCP recognized that the patient had abnormal A1C and initiated lab work on the patient to follow his newly diagnosed DM. PCP counseled the patient on diet and exercise and his newly prescribed medication (Metformin) for DM. Although the PCP counseled the patient on the effects of Metformin, the PCP did not follow-up on the patient's blood sugar to see how the medication was impacting the patient's glucose levels. The patient also suffered from bradycardia and the PCP ordered an echocardiogram in regards to sinus bradycardia and left ventricular hypertrophy (LVH). It is recommended that the PCP consider thyroid stimulating hormone (TSH) or additional testing if more symptoms are present, since the patient had no shortness of breath (SOB) and no edema.
Case 9	***Adequate.*** A sixty-two year old patient with multiple chronic conditions: Diabetes Mellitus Type II (DMII), HTN, Hyperlipidemia and GERD. During the audit review period, management of this patient was deemed as adequate; the patient was provided GERD counseling which included recommendations such as avoiding caffeine, citrus, and tomato based products.
Case 10	***Adequate.*** A forty-three year old patient with chronic Hepatitis C (HCV) and a failed past interferon (IFN) treatment. During the audit review period adequate management of this patient was given.
Case 11	***Adequate.*** A thirty-seven year old patient with a history of symptomatic hypogonadism followed by Endocrine. The patient was also diagnosed with a Vitamin D deficiency and given a prescription for Vitamin D. The patient receives injections at the hub. During the audit review period adequate management of this patient was given.
Case 12	***Adequate.*** A fifty-six year old patient with Pre-Diabetes, HTN and hyperlipidemia. The PCP provided appropriate management of the patient's elevated Liver Function Test (LFT) with cessation of statin. There was one deficiency associated with this case; on November 6, 2015, a Hepatitis Panel was ordered by the PCP but there was no rationale why the lab was ordered and no documentation of follow-up after the lab.
Case 13	***Inadequate.*** A thirty-eight year old patient being followed for severe chronic knee pain and work up for possible HCV treatment. In October 2015, the patient was referred to the hub for a liver biopsy for pursuit of HCV treatment; there was no indication that there was a referral generated, however there was documentation that the PCP and the Chief Medical Officer at the hub institution discussed ordering a Fibroscan for the patient. Patient's Fibroscan results were consistent with F3 significant fibrotic liver. During the patient's chronic care appointment for chronic knee pain and HCV the PCP failed to document the patient's history and physical assessment, only stating "severe right knee pain which is poorly controlled with Naprosyn" which does not support the patient's pain management for knee pain. It is recommended if the patient

	needs more severe pain management such as narcotic treatment for knee pain, then he should be transferred to the hub institution for higher level of care.
Case 14	***Inadequate.*** A thirty-four year old patient with GERD, chronic low back pain (LBP) and pterygium. During the audit review period several deficiencies were identified with this case. Below are the deficiencies: ▪ PCP ordered unnecessary work up for x-rays. ▪ PCP did not discuss the long term symptom control of GERD with the patient; diet and exercise were not discussed. ▪ PCP did not consider the need for tests such as h. pylori and upper endoscopy (EGD). ▪ Patient had several refills of Prilosec but no abdominal symptoms were addressed. ▪ Medication management for LBP changed without justification; patient was on Tylenol then subsequently changed to a nonsteroidal anti-inflammatory drug (NSAID).
Case 15	***Adequate.*** A thirty-eight year old patient with HTN, headache (HA) status post head injury, hyperlipidemia. During the audit review period the patient also requested a low bunk and soft shoe chrono. The three deficiencies associated with this case all centered around the PCP's documentation of the patient's sick call appointments. The PCP documented insufficient information on the diagnosis of dyspepsia; the PCP failed to document the inherent risks and side effects with taking unnecessary medications, and failed to support his diagnosis with documentation. The PCP failed to provide documentation why the soft shoe or low bunk chronos were justified. Soft shoe chronos are no longer utilized and this information was not indicated in the patient's medical record.

The overall clinical care provided at GSMCCF is deemed adequate, which is attributed to the good sound decision-making of the PCP. The CCHCS physician has provided GSMCCF with the following recommendations on how to improve their performance:

- Provider shall increase documentation to support the line of thinking to include pertinent positive and negative findings for diagnoses such as atypical chest pain.
- Provider shall document rationale for diagnoses and plans; perform exams on body systems related to diagnoses on clinic encounter; for example, inspection, palpation, range of motion, deep tendon reflexes, observation of gait for low back pain.
- Provider shall order appropriate follow up and not on a PRN (as necessary) basis for certain cases e.g., why is a steroid cream given for a facial rash for 180 days without follow up?
- Provider shall address abnormal vital signs such as a pulse of 42; circling them is insufficient.
- Provider shall utilize resources such as *Up-to-Date*; CCHCS Formulary, Clinical Guidelines and Policies found on the *California Prison Health Care Services* (CPHCS) website http://www.CPHCS.ca.gov, in order to access the latest CCHCS pharmacy formulary, clinical guidelines, and policies.
- Provider shall not give medications for GERD and abdominal pain for extended periods without review of symptoms.
- Provider shall order labs based on evidence-based guidelines; utilize *Up-to-date*, and other resources to support the use of screening labs; for example, Hep A, B, C labs should not be ordered without a valid reason.
- The facility shall maintain a separate binder for the CCHCS *Inmate Medical Services Policies and Procedures* and this binder shall be made readily accessible to all health care staff for reference.

- Provider shall review the CCHCS and Center for Disease Control resources provided on TB screening and indications for chest x-ray.
- The facility shall email the PPCMU Medical Records mailbox at M_PPCMU.MRS@cdcr.ca.gov to request missing documentation of labs, imaging, and immunizations, for those patients arriving directly from the out-of-state facilities.
- Provider shall order Hep C Antibody testing by itself if there is no indication to order the Hepatitis A and B tests.
- Provider shall **only** order x-rays for cases with a strong clinical indication, for example, ordering an x-ray for L-Spine change management in a patient with chronic stable low back pain is not necessary.
- Provide shall refer *Up-to-Date* for American Diabetes Association (ADA) recommendations and outcome studies on intensive therapy versus less stringent therapies for effective Diabetes management of hemoglobin A1C.. The ADA recommends a goal of 7% with more stringent goals on an individual basis.
- Provider shall recognize that acute sinusitis is more often viral than bacterial and use antibiotics more conservatively.
- Provider is recommended to use regular ink pens for documentation in the medical records in order to improve legibility.
- When documenting a plan for follow up on progress notes or lab result forms, the provider should document a time frame for follow-up. The provider shall not write "follow up as scheduled" which does not confirm an appointment has been made.
- Chest x-rays for a history of positive TB skin test with negative chest x-ray is not needed unless there is a clinical indication. Provider shall refer to the CCHCS and CDC guidelines on TB screening.
- The facility shall implement a process to educate health care staff on good hand washing techniques and mandate staff to change gloves after each PPD skin test is administered.

PRIOR CRITICAL ISSUE RESOLUTION

The audit from May 2015 resulted in the identification of 14 quantitative critical issues. On November 3, 2015, CCHCS auditors performed a Corrective Action Plan (CAP) Review where the previously identified critical items were reviewed. At the time of the CAP review 13 of the 14 items were found to be resolved with only one critical issue remaining open. It should be noted that the one remaining critical item question has been removed from the current audit instrument and has been closed during this current audit.

NEW CRITICAL ISSUES

As a result of the current audit, there were 23 new critical issues identified. All newly identified "Critical Issues" have been addressed in the *Audit Findings – Detailed by Quality Indicator* section of the report.

CONCLUSION

During the current audit, the facility's overall performance was rated *inadequate.* Of the 15 quality indicators evaluated, CCHCS auditors found four *proficient*, six *adequate* and five *inadequate* (see Executive Summary Table on page 4). GSMCCF can be commended on maintaining 100% compliance on all 14 prior critical issues; none have been reopened during this current audit. The root cause of the majority of the 23 new critical issues is a direct result of the lack of nursing documentation of treatment, maintenance of monitoring logs, expired BLS certification of first responders (custody staff), and maintaining and checking the emergency response bags.

The deficiencies identified in, the *Health Appraisal/Health Care Transfer* and *Specialty Services* indicators create barriers preventing the patients from receiving an adequate level of care for California patients housed at this facility. GSMCCF is required to provide each patient with an initial health screening along with a complete screening for signs and symptoms of TB upon their arrival. RN staff have failed to consistently document a face-to-face assessment of the patient upon his return from a specialty consult appointment or hub institution visit. Additionally, the RN staff has failed to consistently notify the PCP of any immediate orders or follow-up instructions provided by the specialty consultant, hub institution or emergency department upon the patient's return. The facility is encouraged to establish self-auditing tools and processes in the areas that require a more focused approach and close monitoring to ensure compliance with the established protocols and guidelines. These critical issues are fixable and are within management's scope of control to ensure compliance on future audits. The facility's management is expected to work with its staff to remedy all critical issues.

During the exit conference, the audit team briefed GSMCCF on all the deficiencies identified in the report. The Warden and HSA were very receptive to the recommendations and constructive feedback presented by the audit team. The Warden and the HSA affirmed that they would work diligently to address all deficient critical issues. GSMCCF is to be commended for their immediate attention in correcting the issue regarding the non-compliant first responders; all were re-certified on BLS the weekend following the audit and documentation provided to the HPS I auditor.

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 sampling of patients housed in general population and administrative segregation units. The results of the interviews conducted at GSMCCF are summarized in the table below.

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

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

Comments:

During the onsite audit in May 2016, the CCHCS auditors' interviewed ten patients for questions one through eight. At the time of the onsite audit, GSMCCF housed one Disability Placement Program (DPP) patient, who participated in the interviews. Included in the ten interviewed patients were four GP patients, one DPP patient and five IAC representatives. Below is summary of the responses from the IAC representatives during their interviews:

IAC Committee interview – During the interview with the IAC committee members, they verbalized positive feedback for the quality of health care being provided. The IAC members brought to the auditors' attention the following issues:

- Patients were complaining of not being granted soft shoe chronos. The members were informed by the physician auditor that these chronos do not exist.
- Patients are complaining that the scheduled pill call times are unpredictable and it interferes with their daily activities. The auditors discussed this issue with the HSA, who stated that with daily custody activities; such as programs, new intake and yard time; patients may be delayed by a few minutes but patients are afforded the opportunity to receive their medications on a daily basis.
- During the TB testing and the influenza vaccinations, patients observed nursing staff not changing gloves after each patient was administered the PPD skin test or influenza shot. This information was passed onto the nursing staff, who will be more vigilant during subsequent mass testing.

1. Regarding questions 1 through 4 – All interviewed patients were aware of the sick call process and had access to the forms, if needed. The patients reported that the nursing staff picks up the sick call slips in the morning hours and patients are seen in the afternoon or the following day.
2. Regarding questions 5 through 8 – All interviewed patients were aware of the grievance/appeal process and had access to the forms, if needed. No patients voiced concern regarding the appeal process.
3. Regarding question 9 – The DPP patient interviewed was able to describe his documented qualifying disability.
4. Regarding question 10 –The DPP patient interviewed was able to describe his documented accommodations (ground floor, lower tier, bottom bunk) for his disability.
5. Regarding question 11 – The DPP patient interviewed was able to describe the process and identify the form used to request reasonable accommodation.
6. Regarding question 12 – The DPP patient interviewed reported he would request a reasonable accommodation form from the facility HSA or housing officer if needed. The auditor informed patient that he could also request a reasonable accommodation form from the facility's ADA coordinator or from any of the health care staff.
7. Regarding question 13 – The patient reported he had received his reasonable accommodation while previously housed in a facility in Arizona. The patient indicated he had not utilized any accommodations as he has recently arrived at GSMCCF a month prior.
8. Regarding question 14 – The patient reported he has previously used the repair services while housed out-of-state, but had not utilized it at GSMCCF.
9. Regarding question 15 – This question was not answered as the patient did not utilize the repair services at GSMCCF.
10. Regarding question 16 – The patient was able to describe the process for filing a grievance/appeal for his disability related issue.

11. Regarding question 17 – The patient reported he did not require any assistance obtaining or completing a CDCR 602-HC Inmate/Parolee Health Care Appeal Form, CDCR 1824 Reasonable Modification or Accommodation Request Form, or similar form, but if needed, he could ask a fellow inmate or health care staff.
12. Regarding question 18 – The patient reported he has not submitted an ADA grievance/appeal in the past.
13. Regarding question 19 – The patient did not know the name of the ADA coordinator, but indicated he would speak with the facility HSA if he needed assistance for his disability. The auditor notified the patient that the ADA coordinator at GSMCCF is the HSA.
14. Regarding question 20 – The patient stated he felt he has access to licensed health care staff to address any issues regarding his disability.
15. Regarding question 21 – The patient stated he felt that health care staff at GSMCCF take their time with him during his medical visits and they explain things in a way he understands. The patient reported he is very satisfied with the health care provided to him at GSMCCF.