September 8, 2016

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

Dear Chief Lozano,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at Shafter Modified Community Correctional Facility (SMCCF) from June 28 through 30, 2016. The purpose of this audit was to ensure that SMCCF is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006. On August 24, 2016, a draft report was sent to you providing the opportunity to review and dispute any findings presented in the draft report. On September 8, 2016, your facility confirmed acceptance of the findings in the report.

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

The audit findings reveal that during the audit review period, SMCCF was providing adequate health care to CDCR patients housed at the facility. However, a number of deficiencies were identified in the following program areas and require facility's immediate attention and resolution:

- Internal Monitoring and Quality Management
- Emergency Medical Response/Drills & Equipment
- Quality of Provider Performance

The deficient program 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, Private Prison Compliance and Monitoring Unit, Field Operations, Corrections Services, CCHCS, at (916) 691-4849 or via email at Donna.Heisser@cdcr.ca.gov.

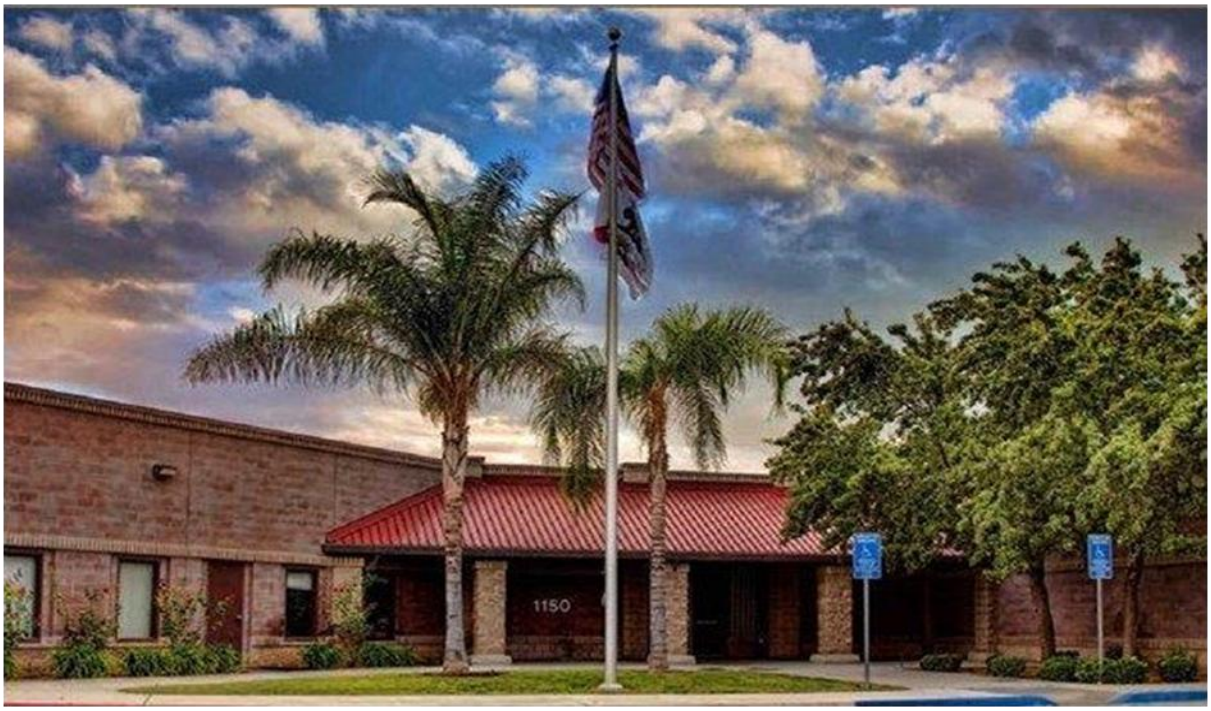
Sincerely,
Don Meier, Deputy Director
Field Operations, Corrections Services
California Correctional Health Care Services

Enclosure

cc: John Dovey, Director, Corrections Services, CCHCS
Joseph W. Moss, Chief, Contract Beds Unit (CBU), California Out of State Correctional Facility (COCF), Division of Adult Institutions (DAI), California Department of Corrections and Rehabilitation (CDCR)
Michael J. Williams, Chief Deputy Administrator, CBU, COCF, DAI, CDCR
David Hill, Chief Executive Officer, Wasco State Prison, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT



Shafter Modified Community Correctional Facility

June 28-30, 2016

TABLE OF CONTENTS

DATE OF REPORT

September 8, 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 Private Prison Compliance and Monitoring Unit (PPCMU) within 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, PPCMU 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 June 28 and 30, 2016, at Shafter Modified Community Correctional Facility (SMCCF), located in Shafter, CA, as well as findings associated with the review of various documents and patient medical records for the review period of December 2015 through May 2016. At the time of the audit, CDCR's *Weekly Population Count*, dated June 24, 2016, indicated a budgeted bed capacity of 640 beds, of which 626 were occupied with CDCR patients.

EXECUTIVE SUMMARY

From June 28 through 30, 2016, the CCHCS audit team conducted an onsite health care monitoring audit at SMCCF. The audit team consisted of the following personnel:

A. Vasudeva, Medical Doctor, Regional Physician Advisor
L. Pareja, RN, MSN, Nurse Consultant Program Review
K. Broussard, Health Program Manager I
V. Lastovskiy, 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 SMCCF. The end product of the quantitative review is expressed as a compliance score, while the end product of clinical case reviews is a quality rating.

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

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

Based on the quantitative reviews and clinical case reviews completed for the 16 applicable operational areas/quality indicators during the audit, SMCCF achieved an overall point value of ***1.2*** which resulted in an overall audit rating of ***adequate***.

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	95.4%	Proficient	Proficient	2.0
2. Internal Monitoring & QM	N/A	82.0%	Inadequate	Inadequate	0.0
3. Licensing/Certification, Training & Staffing	N/A	85.7%	Adequate	Adequate	1.0
4. Access to Care	Adequate	93.9%	Proficient	Proficient	2.0
5. Chronic Care Management	Inadequate	97.3%	Proficient	Adequate	1.0
6. Community Hospital Discharge	Proficient	100.0%	Proficient	Proficient	2.0
7. Diagnostic Services	Adequate	86.1%	Adequate	Adequate	1.0
8. Emergency Services	Adequate	N/A	N/A	Adequate	1.0
9. Health Appraisal/Health Care Transfer	Adequate	98.1%	Proficient	Proficient	2.0
10. Medication Management	Adequate	91.0%	Proficient	Adequate	1.0
11. Observation Cells	N/A	N/A	N/A	N/A	N/A
12. Specialty Services	Adequate	97.2%	Proficient	Adequate	1.0
13. Preventive Services	N/A	93.8%	Proficient	Proficient	2.0
14. Emergency Medical Response/Drills & Equipment	N/A	84.6%	Inadequate	Inadequate	0.0
15. Clinical Environment	N/A	93.3%	Proficient	Proficient	2.0
16. Quality of Nursing Performance	Adequate	N/A	N/A	Adequate	1.0
17. Quality of Provider Performance	Inadequate	N/A	N/A	Inadequate	0.0
				Average	1.2
				Overall Audit Rating	Adequate

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 12) 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 PPCMU 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*, 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, a clinical case review section has been added to the audit process. This will help PPCMU 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*, PPCMU 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. PPCMU 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, PPCMU 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 three administrative components are: *Administrative Operations, Internal Monitoring and Quality Management and Licensing/Certifications, Training and Staffing.*

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

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

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

The 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 (CAP) 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 – Shafter Modified Community Correctional Facility	
Question 1.2	The facility's local operating procedures/policies are not all in compliance with the *Inmate Medical Services Policies and Procedures*.
Question 2.3	The Quality Management Committee does not include the monitoring of defined aspects of care in its review process.
Question 2.10	The CDCR 602-HC Forms, *Patient-Inmate Health Care Appeals,* are not readily available to patients in all housing units.
Question 3.9	The peer review of the facility's provider is not being completed within the required time frames.
Question 4.6	The registered nurses do not consistently document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data.
Question 4.8	The registered nurses do not consistently document that effective communication was established and that education related to the treatment plan was provided to the patient.
Question 7.1	The patients' diagnostic tests are not consistently completed within the time frame specified by the provider.
Question 7.2	The primary care provider does not consistently review, sign, and date the patients' diagnostic test report(s) within two business days of facility's receipt of results.
Question 9.2	The registered nurses do not consistently document an assessment of the patient if the patient answered 'yes' to any of the medical problems listed on the *Initial Health Screening* form.
Question 10.5	The registered nurses interviewed regarding the process of administering direct observation therapy medications were not fully knowledgeable on the process.
Question 10.7	The facility's nursing staff are not all familiar with the medication error reporting process.
Question 13.3	The facility does not monitor the patient monthly while the patient is on the anti-Tuberculosis medication.
Question 14.4	The facility's Emergency Medical Response Review Committee (EMRRC) meeting minutes are not signed by the Chief and Health Services Administrator.
Question 14.7	The facility's emergency medical response bag is not consistently re-supplied and re-sealed before the end of the shift, if the emergency medical response and/or drill warranted an opening of the bag.
Question 15.10	The facility's biohazard waste is not located in the appropriate location and is not properly secured and labeled.

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

AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR

1. ADMINISTRATIVE OPERATIONS

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
95.4% [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 95.4% in the *Administrative Operations* indicator, equating to the overall rating of *proficient*. However, as evidenced by the rating below, not all of the facility's policies and LOPs were found in compliance with IMSP&P guidelines. It should be noted that the majority of the facility's LOPs were merely a copy of the IMSP&P and in many cases were not specifically related to SMCCF's actual operating procedures. This issue was addressed during the onsite audit and the facility was strongly encouraged to update the policies to make them specific to SMCCF's procedures while at the same time ensuring they are in compliance with IMSP&P guidelines and requirements.

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?	5	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?	12	3	80.0%
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?	7	1	87.5%
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?	1	0	100%
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:			**95.4%**

Comments:

1. Question 1.2 – Of the 15 LOPs reviewed, 3 were found non-compliant with IMSP&P guidelines. Specifically, policies related to Chemical Agents/Use of Force, Medication Management, and Blood-borne Pathogen Exposure. This equates to 80.0% compliance. The following deficiencies were identified within the aforementioned policies:

   - *Chemical Agents/Use of Force* – The LOP lacks essential components such as: decontamination procedures following controlled use of force and evaluation and medication documentation following an assault, cell extraction or application of use of force.
   - *Medication Management* – Important changes were made to the Medication Management policy in IMSP&P in January 2016 that were not reflected in SMCCF's LOP such as:
     - Keep-on-person (KOP) medication pick-up is now within four business days of the medication becoming available versus the previous two day requirement.
     - IMSP&P no longer requires primary care provider (PCP) referral if a patient missed a dose of Insulin.
     - Critical medications are now listed in IMSP&P. If a patient missed a critical medication, the patient shall be seen by a licensed health care staff within 24 hours when being referred for missing or refusing doses of critical medication.
     - Administration of medication within eight hours of arrival for new intakes.
     - SMCCF's LOP does not cover medication availability process for non-urgent new medication orders and non-urgent renewed medication orders.
   - *Blood-borne Pathogen Exposure* – The LOP lacks procedures regarding medical intervention for significant exposure incident, i.e., certain appropriate medical interventions must be initiated promptly within two hours to be maximally effective.

2. Question 1.5 – Based on the review of the *Contractor's Log-on Report* provided to PPCMU by CCHCS Information Technology (IT) department, one of the facility's registered nurses (RN) does not log-on or access the electronic Unit Health Record (eUHR) and/or Quest 360 system at least once a month. The RN's account was created on February 18, 2016 and the staff member last logged on to the system on February 19, 2016. Of the eight health care staff members assessed for this requirement, one RN was found non-compliant. This equates to 87.5% compliance. It should be noted that this RN's access to the eUHR/Quest 360 was reset one week prior to the onsite audit.

3. Question 8 – Not Applicable. There were no third party requests for release of patient health care information received by the facility during the audit review period; therefore, this question could not be evaluated.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
82.0% [Inadequate]
Overall Rating:
Inadequate

In addition, the facilities are required to utilize monitoring logs (provided by PPCMU) to document and track all patient medical encounters such as initial intake, health appraisal, sick call, chronic care, emergency/hospital services and specialty care services. These logs are reviewed by PPCMU staff on a monthly or a weekly basis to ensure accuracy, timely submission and to determine 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, review of QMC meeting minutes, review of patient first level health care appeals and review of the facility's monitoring logs.

SMCCF received a compliance score of 82.0% in the *Internal Monitoring and Quality Management* indicator, equating to an overall quality rating of *inadequate*. Nine of the 13 questions assessed in this component scored in the *proficient* range (90% and above), two scored in the *adequate* range, and two questions scored in the *inadequate* range (below 85.0% compliance).

Quantitative Review Results

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

Internal Monitoring & Quality Management		Yes	No	Compliance
2.1	Does the facility hold a Quality Management Committee a minimum of once per month?	6	0	100%
2.2	Does the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	4	0	100%
2.3	Does the Quality Management Committee's review process include monitoring of defined aspects of care?	0	4	0.0%
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?	85	8	91.4%
2.5	Are the dates documented on the sick call monitoring log accurate?	47	6	88.7%
2.6	Are the dates documented on the specialty care monitoring log accurate?	23	2	92.0%
2.7	Are the dates documented on the hospital stay/emergency department monitoring log accurate?	7	1	87.5%

2.8	Are the dates documented on the chronic care monitoring log accurate?	54	6	90.0%
2.9	Are the dates documented on the initial intake screening monitoring log accurate?	55	5	91.7%
2.10	Are the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* readily available to patients in all housing units?	2	6	25.0%
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?	9	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?	1	0	100%
	Overall Quantitative Review Score:			**82.0%**

Comments:

1. Question 2.3 – This question was rated based on documentation in the minutes from the four QMC meetings where it was notated that a CAP was required. For the months of January, February, April and May 2016, the QMC's review process did not include documentation of monitoring of defined aspects of care (validation audits); therefore, compliance with this requirement equates to 0.0%.

2. Question 2.4 – During the audit review period of December 2015 through May 2016, 93 submissions of monitoring logs were required. Of the 93 monitoring logs submitted, 85 were submitted on time. The weekly monitoring logs were submitted late on December 15, 2015 and February 2, 2016. The monthly monitoring logs were submitted late on February 5, 2016. This equates to 91.4% 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	27	25	2
Specialty Care	weekly	27	25	2
Hospital Stay/Emergency Department	weekly	27	25	2
Chronic Care	monthly	6	5	1
Initial Intake Screening	monthly	6	5	1
	Totals:	**93**	**85**	**8**

3. Question 2.5 – A total of 53 entries were randomly selected from the weekly sick call monitoring logs to assess the accuracy of the dates reported on the log. Of the 53 entries reviewed, 47 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. This equates to 88.7% compliance. Discrepancies identified within the remaining six entries were due to:

   - incorrect date of when the sick call request was received and reviewed (two entries);
   - incorrect date of RN face-to-face encounter (one entry);
   - incorrect CDCR number for the patient documented on the log (one entry);
   - missing CDCR Form 7362, *Health Care Services Request*, in the eUHR; therefore unable to determine validity of dates recorded on the log (two entries).

4. Question 2.6 – A total of 25 entries were randomly selected from the weekly specialty care monitoring logs to assess the accuracy of the dates reported on the log. Of the 25 entries reviewed, 23 were found to be accurate with dates matching the dates of service reflected in the patients' medical record. This equates to 92.0% compliance. Discrepancies identified within the remaining two entries were due to an incorrect PCP referral date documented on the log.

5. Question 2.7 – A total of eight entries were reviewed from the weekly hospital stay/emergency department monitoring logs to assess the accuracy of the dates reported on the log. Of the eight entries reviewed, seven were found to be accurate with dates matching the dates of service reflected in the patients' medical records. This equates to 87.5% compliance. The discrepancy identified within the remaining one entry was due to the incorrect date of patient's admission to the hospital documented on the log.

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 log. Of the 60 entries reviewed, 54 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. This equates to 90.0% compliance. Six discrepancies were due to:

    - missing documentation validating the date actual PCP assessment occurred (five entries);
    - missing documentation validating the PCP's last assessment date (one entry).

7. Question 2.9 – A total of 60 entries were selected from the monthly initial intake screening monitoring logs to assess the accuracy of the dates reported on the log. Of the 60 entries reviewed, 55 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. This equates to 91.7% compliance. Discrepancies identified within the remaining five entries were due to:

    - missing CDCR Form 7277, *Initial Health Screening*, from the patient's medical record; therefore, unable to validate the date of initial health screening (one entry);
    - missing CDCR Form 196-B, *Intake History and Physical,* from the patient's medical record; therefore, unable to validate the date of health appraisal (three entries);
    - incorrect date of health appraisal (one entry).

8. Question 2.10 – Of the eight dorms inspected during the tour of the facility, SMCCF had CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* readily available to patients in two of the dorms. The rest of the dorms had the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* stored in a locked cabinet inside the dorm. This equates to 25.0% compliance. The audit team recommended the facility install a shelf or attach a form holder to the wall where the forms can be visible and readily accessible by patients.

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]:
85.7% [Adequate]
Overall Rating:
Adequate

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.

SMCCF received a marginally *adequate* compliance score of 85.7% in the *Licensing/Certifications, Training & Staffing* indicator. Six of the seven question assessed in this component scored in the *proficient* range and one scored in the *inadequate* range.

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?	73	0	100%
3.3	Did all health care staff receive training on the facility's policies based on Inmate Medical Services Policies and Procedures requirements?	8	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	0.0	100%
3.6	Does the facility have the required nurse staffing complement per contractual requirement?	5.2	0.0	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	2	0.0%
	Overall Quantitative Review Score:			**85.7%**

Comments:

1. Questions 3.7 and 3.8 - These questions are not applicable to in-state correctional facilities.
2. Question 3.9 – The facility physician's first peer review was completed on May 6, 2016, nine months after the hire date. However, during the physician's nine month tenure at the facility, the facility was required to complete an initial (10 day) review and 60 day follow-up review; none of which were completed. As the facility did not meet any of the required time frames with regard to completing the peer reviews, this requirement equates to 0.0% compliance. This issue was addressed during the exit conference and the facility notified the audit team that the physician's follow-up to the May 2016 peer review will be completed by mid August 2016.

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 to confirm there is continuous availability of CDCR Form 7362*, Health Care Services Request*.

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
93.9% [Proficient]
Overall Rating:
Proficient

For *Access to Care* indicator, the case review and quantitative review processes yielded different results. The case review received an *adequate* rating while the quantitative review resulted in overall score of 93.9% compliance, equating to a quality rating of *proficient*. 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. The CCHCS physician's case review identified a couple of minor physician deficiencies related to access to medical care and the nursing case review did not identify any nursing deficiencies. As such, the quantitative review's *proficient* rating was deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

The CCHCS clinicians reviewed 35 encounters related to *Access to Care* – 26 nursing encounters and 9 provider encounters. The CCHCS nurse auditor did not identify any deficiencies related to nursing performance in this area. However, three deficiencies were found relative to the provider's performance. Specific examples of deficiencies and areas of concern identified by CCHCS physician are as follows:

- In Case 2, a patient was seen twice by the provider for complaint of abdominal pain. On both occasions, the provider failed to complete a physical examination of the patient.
- In Case 13, following the RN's referral, the patient was seen by the provider for a spider bite. During the visit, the provider failed to address the patient's elevated blood pressure of 166/99.

Based on review of the 35 encounters related to access to care and the identified deficiencies, that for the most part, were minor in nature and did not adversely affect the patient's health care condition; the CCHCS clinicians determined the quality of physician and nursing care in access to care was *adequate*.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which consisted of onsite inspections/observations, review of patient electronic medical records, and/or review of various documents and tracking logs. Following the 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	0	100%
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?	23	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?	21	3	87.5%
4.6	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	19	4	82.6%
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?	13	11	54.2%
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?	23	1	95.8%
4.10	If the registered nurse determines the patient's health care needs are beyond the level of care available at the facility, does the nurse contact or refer the patient to the hub institution? (MCCF Only)	2	0	100%
4.11	If the patient presented to sick call three or more time for the same medical complaint, does the registered nurse refer the patient to the primary care provider?	1	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?	9	0	100%
	Overall Quantitative Review Score:			**93.9%**

Comments:

For questions 4.1 through 4.11, a random sample of 24 patient medical records was reviewed for the audit review period of December 2015 through May 2016.

1. Questions 4.1 and 4.2 – One record was found not applicable as the patient did not complete a CDCR Form 7362, *Health Care Services Request*, since it was an urgent walk-in, followed by a transfer to community hospital for a higher level of care.

2. Question 4.5 – Twenty-one patient medical records reviewed showed that the RN conducted a focused subjective/objective assessment based on the patient's chief complaint. The remaining three records were found non-compliant; one was due to poor objective assessment, no measurement of skin lesions, and no documentation of present medications and known allergies. The other one was the result of a very brief physical assessment of the left forearm, missing documentation of current medications, medication compliance and known allergies. The third record was missing documentation of the patient's current medications and known allergies. This equates to 87.5% compliance.

3. Question 4.6 – One of the 24 medical records reviewed was not applicable as it did not meet the criteria for this question. Nineteen patient medical records included documentation of a nursing diagnosis related to subjective/objective assessment data. The four non-compliant cases did not include documentation of a complete nursing diagnosis. This equates to 82.6% compliance.

4. Question 4.8 – Thirteen patient medical records included documentation that effective communication was established and education related to the treatment plan was provided to the patient. The remaining

11 cases were missing nurse's documentation of effective communication having been established. This equates to 54.2% compliance.

5. Question 4.9 – Twenty-three patient medical records included documentation that following the RN's referral, the patient was seen by a provider within the required time frame. For the one non-compliant record, there was no documentation found to indicate the patient was seen by a PCP for the patient's third complaint of a head cold. This equates to 95.8% compliance.
6. Questions 4.12 and 4.13 – Not applicable. These questions do not apply to in-state correctional facilities.

5. CHRONIC CARE MANAGEMENT

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

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
97.3% [Proficient]
Overall Rating:
Adequate

The case review received an *inadequate* rating while the quantitative review resulted in overall score of 97.3% compliance, equating to a quality rating of *proficient*. 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. Considering that 50 percent of the identified clinical case review deficiencies were related to health information management and had little effect on the patient's medical condition, the CCHCS clinicians determined that an *adequate* rating was a more accurate reflection of the overall indicator rating.

Case Review Results

The CCHCS physician reviewed 17 encounters and the CCHCS nurse auditor reviewed 6 encounters related to *Chronic Care Management* indicator. Out of a total of 23 encounters reviewed, 14 deficiencies were found, of which 3 were related to nurses' performance and 11 were related to the provider's performance. Two of the three nursing deficiencies were the result of missing documentation in the patient's medical file indicating a finger stick blood sugar (FSBS) check was done as ordered by the provider. The other deficiency was due to nursing staff not carrying out the frequency of FSBS checks as ordered by the provider.

Of the 11 provider deficiencies noted, 5 were related to health information management; such as the provider failing to document in the assessment section of the progress note, the control and clinical trend of conditions for which the patient was being seen. The remaining six physician deficiencies include:

- In Case 1, on two separate occasions, the patient was seen in chronic care clinic for follow-up on hypercholesterolemia and diabetes. On both occasions, the provider failed to address diabetes. During one of the visits, the provider did not address the elevated blood pressure. At the other visit, the provider did not document results of A1C (blood sugar) test.

- In Case 4, the patient was seen for follow-up on diabetes. There was no documentation of the provider educating the patient on the potential risks of stopping Metformin medication. There was also no documentation of A1C or other pertinent lab tests.
- In Case 5, the patient was seen in medical for follow-up on hypertension. The provider, during an examination of the patient, noted heart murmur on the progress note; however, the issue was not addressed further.
- In Case 6, the patient was seen in chronic care clinic for follow-up on hypertension and hypercholesterolemia; however, the provider failed to address the hypercholesterolemia.

Based on the number of deficiencies listed above, the CCHCS clinicians found the quality of clinician care in chronic care management services as *inadequate*.

Quantitative Review Results

The table below reflects the findings/results associated with the quantitative 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.

Chronic Care Management		**Yes**	**No**	**Compliance**
5.1	Is the patient's chronic care follow-up visit completed as ordered?	28	2	93.3%
5.2	Are the patient's chronic care medications received by the patient without interruption within the required time frame?	27	2	93.1%
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?	1	0	100%
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?	1	0	100%
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?	1	0	100%
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:			**97.3%**

Comments:

For questions 5.1 through 5.6, a random sample of 30 patient medical records was reviewed for the audit review period of December 2015 through May 2016.

1. Question 5.1 – Twenty-eight patient medical records included documentation that the patient's chronic care follow-up visit was completed as ordered by provider. Two records were non-compliant with this requirement. In one case, the PCP ordered a 90 day follow-up; however, the patient was not seen for 180 days. In another case, the auditor was unable to locate documentation in the eUHR that the chronic care visit took place on the date recorded on the monitoring log. This equates to 93.3% compliance.

2. Question 5.2 – One of the 30 medical records reviewed was found not applicable as it did not meet the criteria for this question. Twenty-seven patient medical records showed that the patient received his chronic care medication without interruption and two were non-compliant with this requirement. This equates to 93.1% compliance. See below for additional information regarding the two non-compliant medical record reviews:

    - Record 1 – the patient failed to request a refill of his KOP chronic care medication for three months and there was no indication of the patient refusing the medication;
    - Record 2 - No indication the inmate received his Lisinopril from March through May 2016. There were no orders for discontinuing the medication found in the eUHR or any indication of the patient refusing the prescribed medication.

3. Questions 5.3 through 5.5 – Twenty-nine records of the 30 randomly selected for review were found not applicable to this question; therefore, the compliance was based on the one applicable record.

4. Question 5.6 – Not applicable. None of the patients within the sample pool were on nurse administered (NA)/direct observation therapy (DOT) medications; therefore, at this time the audit team is unable to determine the facility's compliance with this requirement.

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:
Proficient
Quantitative Review Score [Rating]:
100% [Proficient]
Overall Rating:
Proficient

During the audit review period of December 2015 through May 2016, a total of eight patients were sent to a community hospital emergency department (ED) for higher level of care. Of these eight patients, four were assessed by the ED provider and returned to the facility the same day and four were admitted to the hospital (patient was under observation for over 24 hours). Of the four patients that were admitted, three were permanently transferred to Wasco State Prison (WSP) upon discharge and one patient has returned to SMCCF. As a result, this quality indicator was assessed for compliance based on this one qualifying case, which as reflected in the findings below was found *proficient*.

Case Review Results

The CCHCS physician, within the clinical cases reviewed did not identify any encounters related to *Community Hospital Discharge*; therefore, the case review rating was based solely on the CCHCS nurse consultant's findings. Of the one qualifying case assessed, there were four encounters identified by the nurse consultant related to *Community Hospital Discharge.* The nurse consultant did not find any lapses in care provided by the SMCCF's nursing staff. As no deficiencies were found, the case review resulted in *proficient* rating for this indicator.

Quantitative Review Results

The table below reflects the findings/results associated with the quantitative review of patient medical records.

	Community Hospital Discharge	Yes	No	Compliance
6.1	*For patients discharged from a community hospital or returned from the hub:* Does the registered nurse review the discharge plan upon patient's return?	1	0	100%
6.2	*For patients discharged from a community hospital or returned from the hub:* Does the registered nurse complete a face-to-face assessment prior to the patient being re-housed?	1	0	100%
6.3	*For patients discharged from a community hospital or returned from the hub:* Is the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	1	0	100%
6.4	*For patients discharged from a community hospital:* Are all prescribed medications administered/delivered to the patient per policy or as order by the primary care provider?	1	0	100%
	Overall Quantitative Review Score:			**100%**

Comments:

None.

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 provided timely, whether the primary care provider completed a timely review of 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]:
86.1% [Adequate]
Overall Rating:
Adequate

For *Diagnostic Services* indicator, the case review and quantitative review findings both resulted in an *adequate* rating. Therefore, the overall indicator rating is determined to be *adequate*.

Case Review Results

The CCHCS clinicians reviewed a total of 31 encounters related to diagnostic services – 24 nursing and 7 provider encounters. Of the 24 nursing encounters assessed, 7 deficiencies were found related to nursing care and performance. Two of the seven nursing deficiencies were a result of the nurse auditor not being able to locate the laboratory reports in the patients' medical record reflecting the laboratory test was completed as ordered by the provider (Cases 5 and 9). Of the remaining five nursing deficiencies, four were due to nursing staff failing to document the type of laboratory exam that was

drawn from the patient (Cases 9 and 10) and one was due to nursing staff not completing the laboratory test within the time frame specified by the provider (Case 6).

Of the seven diagnostic related visits reviewed by CCHCS physician, two deficiencies were noted:

- In Case 3, the patient was seen for follow-up on hypothyroidism and physician ordered an A1C test; however, there was no justification documented reflecting the reason or medical necessity for the test.
- In Case 9, the patient was seen by the provider for a follow-up on knee pain. The provider ordered a laboratory test; however, there was no documentation in the progress note indicating the reason for the laboratory test, which was not medically necessary based on the patient's complaint.

As the above listed deficiencies were minor in nature and did not significantly affect patient care, the case review resulted in an *adequate* rating for this indicator.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review of patients' electronic medical records. 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?	15	3	83.3%
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?	14	4	77.8%
7.3	Is the patient given written notification of the diagnostic test results within two business days of receipt of results?	16	2	88.9%
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?	17	1	94.4%
	Overall Quantitative Review Score:			**86.1%**

Comments:

For questions 7.1 through 7.4, a random sample of 18 patient medical records was reviewed for the audit review period of December 2015 through May 2016.

1. Question 7.1 – Fifteen patient medical records included documentation that the diagnostic test was completed within the time frame specified by the PCP. Three records were non-compliant with this requirement as the lab order was not completed within the time frame specified by the PCP. This equates to 83.3% compliance.
2. Question 7.2 – Fourteen patient medical records included documentation that the provider reviewed, signed, and dated the patient's diagnostic test report within two business days of receipt of results. For the four non-compliant cases, the diagnostic test was not signed and dated by the PCP within two business days of receipt of results. This equates to 77.8% compliance.

3. Question 7.3 – Sixteen patient medical records included documentation that the patient was given written notification of the diagnostic test results within two business days of receipt of results. Two records were found non-compliant; one due to missing documentation of written notification of ultrasound results and the other one due to the facility failing to provide the patient with written notification of the diagnostic test results within the required time frame. This equates to 88.9% compliance.
4. Question 7.4 – Seventeen patient medical records included documentation that the patient was seen by the provider for clinically significant/abnormal diagnostic test results within 14 days and one record was found non-compliant due to missing documentation indicating a follow-up visit for abnormal lab results occurred within the specified time frame. This equates to 94.4% 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

Of the seven urgent/emergent encounters reviewed by CCHCS clinicians, one minor deficiency was noted related to nursing performance. In Case 8, the patient was sent to community hospital ED for further evaluation and treatment. The auditor was unable to locate nursing notes related to the emergency transfer such as: the medical condition of the patient at time of transfer, the time the transfer took place, and the mode of transportation. As this deficiency was minor in nature and had minimal to no effect on patient care, the case review resulted in an overall *adequate* rating for this indicator.

9. HEALTH APPRAISAL/HEALTH CARE TRANSFER

This indicators 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.

As the case review deficiencies were mainly due to missing or incomplete documentation and the quantitative review resulting in 10 questions receiving a 100 percent compliance rating, the CCHCS clinicians determined that a *proficient* rating was a more accurate reflection of the overall indicator rating.

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
98.1% [Proficient]
Overall Rating:
Proficient

Case Review Results

Of the 16 patient encounters/visits reviewed, related to *Health Appraisal/Health Care Transfer Process*, 3 minor deficiencies were found, 1 in nursing care and 2 in provider care. In Case 6, the nurse auditor was unable to find the receiving facility's nursing documentation related to the transfer process such as a complete CDCR Form 7371, *Heath Care Transfer Information*, CDCR Form 7277, *Initial Health Screening*, RN face-to-face evaluation, and a countersigned CDCR Form 7371, *Heath Care Transfer Information.* The two minor provider deficiencies were due to the provider failing to make a further assessment of the patient who was noted to have chronic obstructive pulmonary disease (COPD) (Case 11) and the provider failing to address a scalp mass (Case 14). The three deficiencies were determined to be minor in nature; therefore, the case review rating for this indicator was deemed *adequate*.

Quantitative Review Results

The table below reflects the findings/results associated with the quantitative review which may consist of onsite inspections/observations and 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.

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?	18	0	100%
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?	11	3	78.6%
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?	2	0	100%
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?	7	0	100%
9.6	If a patient was enrolled in a chronic care program at a previous facility, is the patient scheduled and seen by the receiving facility's primary care provider within the time frame ordered by the sending facility's chronic care provider?	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?	1	0	100%

9.8	Does the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	18	0	100%
9.9	Does the patient receive a complete health appraisal within seven calendar days of arrival?	18	0	100%
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?	15	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?	15	0	100%
9.12	Does the Inter-Facility Transfer Envelope contain all the patient's medications, current Medication Administration Record and Medication Profile?	1	0	100%
	Overall Quantitative Review Score:			**98.1%**

Comments:

For questions 9.1 through 9.11, a random sample of 18 patient medical records was reviewed for the audit review period of December 2015 through May 2016.

1. Question 9.2 – Four patient medical records were found not applicable to this question. Of the remaining 14 patient medical records reviewed, 11 included documentation that the RN assessed the patient if the patient answered 'yes' to any of the medical problems listed on the CDCR 7277, *Initial Health Screening,* form. For the three non-compliant cases, the screening nurse failed to document an assessment for the medical problem. This equates to 78.6% compliance.
2. Question 9.4 - 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.

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]:
91.0% [Proficient]
Overall Rating:
Adequate

For *Medication Management* indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in an overall score of 91.0%, equating to a quality rating of *proficient*, while the case review resulted in an *inadequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the critical nature of the deficiencies identified during the medical record and clinical case reviews for their potential impact on the patient's health care condition. Although the case review resulted in several deficiencies; the nursing deficiencies were minor in nature and did not have a significant impact on care provided to patients. The physician deficiencies although significant, were mostly due to lack of physician's documentation and justification for the medical action taken.

Taking into consideration the results of the compliance and clinical case reviews, the CCHCS clinicians determined the appropriate overall rating for the *Medication Management* indicator was *adequate*.

Case Review Results

The CCHCS clinicians reviewed a total of 135 encounters related to medication management and found 27 deficiencies, 16 in nursing performance and 11 in provider's performance.

Of the 16 nursing deficiencies found, 7 were due to the auditor being unable to find physician's orders related to the medications being given to the patient (Cases 4 and 9). Five deficiencies were a result of the KOP medications not having been refilled timely; delays ranged from one to three days in patient receiving the prescribed medication. Specifically, in Cases 1, 3, and 10, there was a one day delay in patient receiving the prescribed KOP medication. In Case 10, there was a three day delay in the patient receiving his Lisinopril medication. The remaining four deficiencies were due to the nurse auditor not being able to find documentation indicating the prescribed medication was given as ordered by the provider. Specific examples are as follows:

- In Case 3, no documentation could be found to determine if Levothyroxine was given in March 2016 as the only Medication Administration Record (MAR) available in the patient's medical record was for the month of April 2016.
- In Case 5, no MAR could be found indicating the patient received Amlodipine in March 2016. The last MAR showed the medication was dispensed as KOP in February 2016.
- In Case 4, a patient missed his afternoon dose of Metformin on February 2 and 14, 2016; however, no refusal form or nurse's progress note could be found indicating the reason for the missed medication.
- In Case 10, no documentation could be found indicating Hygroton medication was administered to the patient as ordered.

The 11 provider deficiencies identified were due to inappropriate medication management such as increasing the dose without justification for such action, starting the patient on the medication not medically necessary or without clear reason and discontinuing the medication without clearly indicating the reason. Specific examples are as follows:

- In Case 2, the patient was seen by a PCP for complaint of knee pain and abdominal pain. The provider prescribed Motrin, which was inappropriate in a patient with unexplained abdominal pain.
- In Case 3, the patient was seen by provider in December 2015 for follow-up on hypothyroidism at which time the provider increased the dose of Levothyroxine medication from 25 micrograms (mcg) to 75 mcg. Five weeks later, the patient was again seen for follow-up on hypothyroidism and lipids. The provider increased the dose of Levothyroxine from 75 mcg to 112 mcg. On both occasions, there was no documentation justifying the reason for an increase in the dosage.
- In Case 4, the patient was seen for follow-up on diabetes. The provider started the patient on Lipitor; however, there was no reason noted for starting the patient on Lipitor and no recent Lipid Panel results could be found in the patient's medical record.

- In Case 5, the patient was seen for follow-up on hypertension. The provider discontinued Aspirin and Lipitor without providing justification for such action.
- In Case 6, the patient was seen for follow-up on hypertension and hypercholesterolemia. There was no clear reason documented by provider as to why the dose of Lisinopril was doubled when patient's blood pressure was essentially near goal.
- In Case 9, the provider prescribed Omeprazole without any medical indication.
- In Case 11, during the history and physical assessment, the provider prescribed Ranitidine without any diagnoses and also prescribed Claritin while patient had no symptoms. A month later, during the follow-up visit, the provider prescribed Naprosyn at patient's request for back pain; however, it was not medically necessary given normal physical exam.
- In Case 13, the patient was seen by provider for complaint of rash and expired medications. The provider prescribed an excessive dose of Diflucan for Tinea cruris (jock itch). There was no documentation reflecting the patient was being started on Amlodipine medication. Lastly, there was no documentation indicating the reason for prescribing hydrocortisone cream and artificial tears.

Eighty-eight percent of the total encounters reviewed related to medication management, did not have any deficiencies; therefore, the case review rating for this indicator was determined to be *adequate*.

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?	18	0	100%
10.3	Does the nursing staff confirm the identity of a patient prior to the delivery and/or administration of medications?	3	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?	4	0	100%
10.5	Does the medication nurse directly observe a patient taking direct observation therapy medication?	2	2	50.0%
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?	4	0	100%
10.7	Are medication errors documented on the Medication Error Report form?	3	1	75.0%
10.8	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food and/or laboratory specimens?	1	0	100%
10.9	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	62	0	100%

10.10	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas?	Not Applicable
10.11	Are the narcotics inventoried at the beginning and end of each shift by licensed health care staff?	Not Applicable
10.12	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers and/or nitroglycerine tablets? (COCF only)	Not Applicable
	Overall Quantitative Review Score:	**91.0%**

Comments:

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

1. Question 10.1 – Seventeen patient medical records reviewed included documentation that the provider educated the patient on the newly prescribed medication(s), and one record was missing such documentation. This equates to 94.4% compliance.
2. Question 10.5 – The facility did not have any patients on nurse administered NA/ DOT medications at the time of the onsite audit; therefore, compliance for this requirement was based on nursing staff interviews. Four nurses were interviewed regarding this process and two failed to mention conducting cup checks to ensure the patient did not leave the medication in his cup. This equates to 50.0% compliance.
3. Question 10.7 – Of the four nursing staff interviewed during the onsite audit (one licensed vocational nurse and three RNs) regarding the medication error process, one RN was not able to correctly describe the process for documenting and reporting medication errors. This equates to 75.0% compliance.
4. Questions 10.10 and 10.11 – Not applicable. SMCCF does not store narcotic medications at the facility; therefore, these questions could not be evaluated.
5. Question 10.12 – Not applicable. This question does not apply to the in-state correctional facilities.

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 SMCCF 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.

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
97.2% [Proficient]
Overall Rating:
Adequate

For *Specialty Services* indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 97.2%, equating to a quality rating 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 patient's health care condition. The case review results revealed just one minor deficiency which did not significantly impact the patient's access to health care. As a result, the CCHCS clinicians determined the appropriate overall rating for this indicator was ***adequate***.

Case Review Results

The CCHCS clinicians reviewed 13 encounters related to *Specialty Services* and found one minor deficiency associated with nursing performance. The CCHCS physician case reviews did not identify any lapses in care provided by the SMCCF's provider. The nursing deficiency was a result of the nursing staff not completely carrying out the provider's order as specified. In Case 6, the provider ordered an x-ray of the patient's right and left knees; however, the radiology report reflects that an x-ray was completed only on the left knee and nursing did not document if there was a change in order. As this deficiency was minor in nature and did not significantly affect patient care, the case review resulted in *adequate* rating for this indicator.

Quantitative Review Results

The table below reflects the findings/results associated with the quantitative 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?	17	1	94.4%

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?	Not Applicable		
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?	18	0	100%
	Overall Quantitative Review Score:			**97.2%**

Comments:

1. Questions 12.1 and 12.2 – Not applicable. These questions do not apply to in-state correctional facilities.
2. Question 12.3 – Seventeen patient medical records included documentation that the RN completed a face-to-face (FTF) assessment prior to the patient's return to the assigned housing unit. One patient's record was missing documentation of an RN's FTF assessment of the patient upon his return from a telemedicine appointment at the hub institution. This equates to 94.4% compliance.
3. Question 12.4 – Not applicable. Of the 18 patient medical records reviewed, none were found applicable to this question; therefore, this requirement could not be evaluated.

13. PREVENTIVE SERVICES

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
93.8% [Proficient]
Overall Rating:
Proficient

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.

The facility received a compliance score of 93.8% in *Preventive Services* indicator, which equates to an overall rating of *proficient*. It should be noted that out of seven compliance tests conducted, three were found not applicable due to either no valid sample available or the question being assessed once in the calendar year per the audit methodology. Refer to the *Comments* section, following the table below, for additional information and details.

Quantitative Review Results

The table on the following page 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?	4	0	100%
13.2	*For patients prescribed anti-Tuberculosis medication(s):* Does the nursing staff notify the primary care provider or a public health nurse when the patient misses or refuses anti-TB medication?		Not Applicable	
13.3	*For patients prescribed anti-Tuberculosis medication(s):* Does the facility monitor the patient monthly while he/she is on the medication(s)?	3	1	75.0%
13.4	Do patients receive a Tuberculin Skin Test annually?	20	0	100%
13.5	Are the patients screened annually for signs and symptoms of tuberculosis?	20	0	100%
13.6	*For all patients:* Were the patients offered an influenza vaccination for the most recent influenza season?		Not Applicable	
13.7	*For all patients 50 to 75 years of age:* Are the patients offered colorectal cancer screening?		Not Applicable	
13.8	*For female patients 50 to 74 years of age:* Is the patient offered a mammography at least every two years?		Not Applicable	
13.9	*For female patients 21 to 65 years of age:* Is the patient offered a Papanicolaou test at least every three years?		Not Applicable	
	Overall Quantitative Review Score:			**93.8%**

Comments:

1. Question 13.2 – Not applicable. There is no indication that the patients who were on anti-tuberculosis (TB) medications during the review period, missed or refused their prescribed anti-TB medications. Therefore, this question could not be evaluated.
2. Questions 13.3 – Three patient medical records included documentation that the patients were monitored monthly while on anti-TB medication. There was no documentation in one patient's medical record indicating the patient was monitored in February 2016 while he was on anti-TB medication. This equates to 75.0% compliance.
3. Question 13.6 – Per the methodology, these questions are evaluated once per calendar year during the time when the onsite audit is conducted within the first half of the fiscal year (July through December). As the current onsite audit for SMCCF was not conducted during the first half of the fiscal year, this question will be evaluated during the subsequent audit.
4. Question 13.7 – Per the methodology, these questions are evaluated once per calendar year during the time when the onsite audit is conducted within the first half of the fiscal year (July through December). As the current onsite audit for SMCCF was not conducted during the first half of the fiscal year, this question will be evaluated during the subsequent audit.
5. 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

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.

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
84.6% [Inadequate]
Overall Rating:
Inadequate

The facility received a compliance score of 84.6%, resulting in an *inadequate* overall rating for the *Emergency Medical Response/Drills & Equipment* indicator. Two out of 12 questions rated below an adequate range of 85.0% compliance and require the facility's immediate attention in resolving these deficiencies. Refer to the *Comments* section, following the table below, for additional information and details on the deficiencies identified during the quantitative review of this indicator.

Quantitative Review Results

The table below reflects the findings/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?	15	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?	15	0	100%
14.4	Does the facility hold an Emergency Medical Response Review Committee a minimum of once per month?	0	6	0.0%
14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	5	0	100%
14.6	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	93	0	100%
14.7	If the emergency medical response and/or drill warrant an opening of the Emergency Medical Response Bag, is the bag re-supplied and re-sealed before the end of the shift?	0	8	0.0%
14.8	If the emergency medical response bag has not been used for emergency medical response and/or drill, is it being inventoried at least once a month?	6	0	100%
14.9	Does the facility's Emergency Medical Response Bag contain only the supplies identified on the Emergency Medical Response Bag Checklist in compliance with Inmate Medical Services Policies and Procedures requirements?	1	0	100%
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?	2	0	100%
	Overall Quantitative Review Score:			**84.6%**

Comments:

1. Question 14.4 – Of the six Emergency Medical Response Review Committee (EMRRC) meetings the facility was required to conduct during the audit review period, the facility held six. However, the meeting minutes were not approved by committee members and signed by the Chief and the Health Services Administrator. This equates to 0.0% compliance.
2. Question 14.7 – All of the eight emergency medical responses/drills reviewed, warranted an opening of the Emergency Medical Response (EMR) bag. The EMR bag logs reviewed for the eight incidents reflect the EMR bag was not restocked and re-sealed before the end of the shift after each incident. This equates to 0.0% compliance.
3. 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]:
93.3% [Proficient]

Overall Rating:
Proficient

The facility received a compliance score of 93.3% in the *Clinical Environment* indicator, equating to an overall rating of *proficient*. The facility received 100% compliance in 13 of the 15 standards/requirements measured; which indicates the facility is performing at a *proficient* level in those areas. Refer to *Comments* section following the table below for information on the two deficiencies identified in this indicator.

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?	Not Applicable		
15.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	Not Applicable		
15.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	3	0	100%
15.4	Does clinical health care staff adhere to universal hand hygiene precautions?	3	0	100%
15.5	Is personal protective equipment readily accessible for clinical staff use?	2	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?	3	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?	31	0	100%
15.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	2	0	100%
15.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	0	2	0.0%
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?	93	0	100%
15.14	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	2	0	100%
15.15	Is the facility's biomedical equipment serviced and calibrated annually?	9	0	100%
15.16	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	0	100%
15.17	Does the clinic visit location ensure the patient's visual and auditory privacy?	2	0	100%
	Overall Quantitative Review Score:			**93.3%**

Comments:

1. Question 15.1 – Not applicable. SMCCF does not use reusable medical instruments; therefore, this question could not be evaluated.
2. Question 15.2 – Not applicable. SMCCF does not utilize autoclave sterilization; therefore, this question could not be evaluated.
3. Question 15.10 – The facility's central biohazard storage location is inside the supply room together with other clinic supplies. Health care staff are in an out of this room as such exposing themselves to the biohazardous materials. The storing of biohazard waste in the clinic's supply room is unacceptable. Additionally, the biohazard waste is not properly secured and labeled. This issue was addressed with nursing staff and facility management and it was recommended the facility identify a different location to store biohazard waste. This equates to 0.0% compliance.

16. QUALITY OF NURSING PERFORMANCE

The goal of this indicator is to provide a qualitative evaluation of the overall quality of health care provided to the patients by the facility's nursing staff. The 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 SMCCF was rated *adequate*. This determination was based upon the detailed case review of all the nursing services provided to 10 patients housed at SMCCF during the audit review period of December 2015 through May 2016. Of the 10 detailed case reviews conducted by the CCHCS nurse consultant, four were found *proficient* and six were found *adequate*. Of 187 total nursing encounters/visits assessed within the 10 detailed case reviews, 27 deficiencies were identified related to nursing care and performance. The majority of the deficiencies involved missing nursing documentation related to carrying out of physician's order, missing laboratory and/or diagnostic reports, and non-compliance with the medication management processes. The nursing services found to be inadequate/deficient at SMCCF include:

- Missing documentation indicating FSBS was done as ordered by provider (identified in Cases 4 and 9).
- Frequency of FSBS not carried out as ordered by provider (identified in Case 4).
- Missing documentation indicating ordered laboratory examinations were completed as ordered by provider (identified in Cases 5 and 9).
- Failure of nursing staff to carry out a laboratory test within the time frame specified by provider (identified in Case 6).
- Failure of nursing staff to document the type of laboratory exam drawn from the patients (identified in Cases 9 and 10).
- Missing and/or incomplete nursing documentation related to the transfer process (identified in Case 6).
- Delay in refill of ordered KOP medications (identified in Cases 1, 3, and 10).
- Missing documentation of the patient receiving prescribed medications (identified in Cases 3, 4, 5, and 10).
- Missing physician's orders related to the medication given to the patient (identified in Cases 4 and 9).

Case Number	Deficiencies
Case 3	***Adequate.*** A thirty-two year old patient with diagnoses of hypothyroidism and hyperlipidemia. During the audit review period, the patient was seen in medical for complaint of swollen hand and persistent cough. The nursing deficiencies include: the nursing staff did not ensure the patient received his KOP medication (Levothyroxine) timely. Also, there was no documentation found in the patient's medical record of a MAR for the month of March 2016 to determine if the patient received his Levothyroxine in March.
Case 4	***Adequate.*** A sixty-one year old patient with diagnoses of diabetes mellitus (DM) and obesity. During the review period, the patient had problems with athlete's feet, watery itchy eyes and heart burn. Additionally, during the review period, the patient refused his medications on several occasions. While the overall nursing services provided to this patient were found to be adequate, there were several issues noted: • The provider ordered to check FSBS twice a day, two times a week for two weeks. The FSBS was not done twice a day on December 10 and 11, 2015 per the Diabetes Monitoring flowsheet. • Nursing staff failed to ensure the patient received his medications as prescribed. The patient missed his afternoon dose of Metformin on February 1 and 14; however, no refusal form could be found and no reason noted by the RN why the patient missed his medication. • Missing physician's order and/or nursing documentation related to the administration of Acetaminophen. • Nursing changed Metformin from DOT to KOP but a physician order indicating the change could not be found in the eUHR.
Case 5	***Adequate.*** A fifty year old patient with chronic diagnoses of hypertension. During the review period, the patient's electrocardiogram (EKG) was abnormal with ST elevations noted, indicating a possible myocardial infarction. The two nursing deficiencies identified in this case resulted from missing documentation reflecting ordered laboratory exams were completed as ordered and missing MAR indicating the patient received Amlodipine in March 2016. The last MAR shows the medication was given as KOP on February 6, 2016.
Case 6	***Adequate.*** A thirty-five year old patient with no chronic diagnoses. During the review period, the patient complained of fever, chills, cough, and weakness. The patient was transported to community hospital ED, treated and returned to the hub institution the same day. While the overall nursing services provided to this patient were found to be adequate, there were a few issues noted: • The provider ordered a routine laboratory test on December 2, 2015; however, the order was not completed until January 4, 2016. • A physician's order for knee x-ray was not completely carried out. The order was for x-ray of bilateral knees but the report only showed one knee was x-rayed. • The nursing staff failed to comply with the health care transfer process. There was no nursing documentation from SMCCF regarding the transfer from SMCCF to the hub institution (WSP). The CDCR Form 7371, *Health Care Transfer Information*, completed by the hub institution was not countersigned by SMCCF's RN. Additionally, there was no initial health screening done on the patient and no RN FTF evaluation completed.
Case 9	***Adequate.*** A forty-seven year old patient with chronic diagnoses of asthma, DM, and hyperlipidemia. During the review period, the patient was diagnosed with mild hypothyroidism. While the overall nursing services provided to this patient were found to be adequate, there were several issues noted: • Nursing staff failed to document the type of laboratory examinations that were drawn from the patient. • Missing blood sugar monitoring flowsheet reflecting that ordered FSBS once a week for six weeks was being carried out as ordered.

- Missing documentation reflecting that a physician's order to collect thyroid-stimulating hormone (TSH) was completed by nursing staff.
- Missing physician's order for a medication (Magnesium/Aluminum Hydroxide/Simethicone) given to the patient.
- Nursing staff did not consistently ensure the patient received his KOP medication timely.

Case 10 ***Adequate.*** A forty-nine year old patient with chronic diagnoses of hyperlipidemia and hypertension. During the review period, the patient submitted sick call requests for blurry vision and dental concern.

While the overall nursing services provided to this patient were found to be adequate, there were a few issues noted:

- Nursing staff did not consistently ensure the patient received his KOP medications timely.
- On two occasions, the nursing staff failed to document the type of laboratory examinations that were drawn from the patient.
- Missing documentation reflecting the prescribed medication (Hygroton) was administered to the patient as ordered by the provider.

The nursing staff should be very diligent in their documentation of every encounter with the patient. One of the essential and basic principles of nursing practice is adequate and accurate documentation. Anything not documented is considered not done. Therefore, it is imperative that nursing documentation is accurate, complete, timely, valid, relevant, and legible. Additionally, nursing staff must be very conscientious in following providers' orders correctly and thoroughly, especially as it relates to medication administration and laboratory examinations.

The facility management staff is expected to take immediate action to resolve the deficiencies identified above. The facility is strongly encouraged to implement oversight and monitoring strategies for the clinical supervisor to evaluate nursing performance in assigned clinical areas and quality of nursing documentation.

17. QUALITY OF PROVIDER PERFORMANCE

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

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

Primary care services at SMCCF are delivered by a single PCP who has been providing his services to the patient population at the facility for 10 months. During the onsite audit, the CCHCS physician auditor spent several hours in discussion with the facility's provider and observed his care for four patients. The provider interacted with patients in a friendly manner, obtained adequate history and conducted adequate physical examination. However, the provider's medical documentation was inadequate; the handwriting was very difficult to read and the provider tends to utilize unapproved abbreviations frequently. Additionally, the PCP was not very familiar with California Code of Regulations, Title 15, pertaining to

medical care for patients and appeared to have minimal knowledge regarding CCHCS medical care policies and procedures and did not know how to utilize the eUHR. For example, the provider saw a Spanish speaking patient who stated his fellow inmate in the waiting area could provide the Spanish to English translation, to which the provider agreed. The provider did not follow through with the inmate translator after CCHCS physician informed him that this was a violation of a CDCR/CCHCS policy and HIPAA.

Case Review Results

The provider's medical care at SMCCF was reviewed for the time period of December 1, 2015 through May 31, 2016 and overall was determined not to meet the applicable standards of care. Of the 15 detailed case reviews conducted by CCHCS physician, none were found *proficient*, seven were *adequate*, and eight were found *inadequate*. Out of a total of 51 physician encounters/visits assessed, 29 deficiencies were noted, which is more than half of all the encounters reviewed. These deficiencies range from severe to minor with a number of them due to missing documentation in the patients' electronic medical record and the remaining deficiencies due to facility provider's illegible handwriting making it extremely difficult to read and determine what has occurred during the patient's visit to medical. In addition, several deficiencies were noted where overall care was nonetheless adequate. The physician findings in this report and recommendations were based upon the observations made during tour of the facility, conversations with medical staff, interview with Inmate Advisory Council (IAC) members, and review of selected medical records.

The physician services found to be inadequate/deficient at SMCCF include:

- No physical examination by provider for patient complaints (identified in Case 2).
- Provider failed to address the patient's chronic care condition during a chronic care appointment (identified in Cases 1 and 6).
- Appropriateness of medical action (abnormal EKG and elevated blood pressure not addressed; scalp mass not addressed; heart murmur and COPD noted but no further assessment conducted) (identified in Cases 5, 11, 13, and 14).
- Unknown reason for laboratory test ordered (identified in Cases 3 and 9).
- Lack of/inadequate documentation to support medical actions taken (identified in Cases 1, 4, 6, and 7).
- Medication prescribed without clinical indication/medical necessity (identified in Cases 2, 4, 9, 11 and 13).
- Medication dose increased without justification for the necessity (identified in Cases 3, 5, and 6).
- Medication discontinued without clear reason (identified in Case 5).

Case Number	Deficiencies
Case 1	***Inadequate.*** A fifty-four year old patient seen three times in medical for follow-up regarding hypercholesterolemia and diabetes. During the chronic care clinic visit in December 2015, the provider prescribed Metformin; however, there were no lab results noted in the progress note. A month and a half later, the patient was again seen in chronic care clinic and during the visit, the provider failed to address patient's elevated blood pressure and diabetes. It is unknown why the patient was taking Omeprazole and Naproxen. In mid April, the patient was seen in chronic care

	clinic and provider, during this visit, again failed to address diabetes. Additionally, no A1C laboratory results were noted and no documentation could be found indicating the provider conducted feet and eye exams.
Case 2	***Inadequate.*** A forty-four year old patient seen three times by provider for complaint of abdominal pain. The provider on two occasions failed to conduct a physical examination of the patient. Additionally, the provider prescribed Motrin, which was inappropriate in a patient with unexplained abdominal pain.
Case 3	***Adequate.*** A thirty-three year old patient seen several times for follow-up regarding hypothyroidism and dyslipidemia. While the overall services provided to this patient were found to be adequate, there were a couple of issues noted. During a visit in December 2015, the provider increased the dose of Levothyroxine medication from 25 mcg to 75 mcg; however, no reason was noted as to why the dose was increased. Five weeks later, the patient was seen in chronic care clinic, and the provider again increased the dose of Levythoroxine medication from 75 mcg to 112 mcg without substantiating the reason for a change in the dose.
Case 4	***Inadequate.*** A sixty-one year old patient seen three times during the review period for follow-up on diabetes. Provider deficiencies identified were due to missing documentation regarding the provider educating the patient on the potential risks of stopping Metformin. Also, there was no documentation of A1C or other pertinent laboratory tests found. Additionally, the patient was started on Lipitor; however, there was no reason documented or recent Lipid Panel results found in the patient's medical record.
Case 5	***Inadequate.*** A fifty year old patient with diagnosis of hypertension seen five times in medical for follow-up. During the December 2015 chronic care appointment, the provider increased the patient's daily dose of Lisinopril medication, which was deemed excessive for blood pressure that was mildly above goal. During the February 2016 chronic care clinic appointment, the provider discontinued Aspirin and Lipitor without noting a clear reason for the action. A month later, the patient was seen again. At this visit, the provider noted a heart murmur; however, the provider failed to address it further.
Case 6	***Inadequate.*** A forty-nine year old patient seen for follow-up regarding hypertension and hypercholesterolemia. During one of the visits, the provider failed to address the hypercholesterolemia and to justify doubling the dose of Lisinopril when the patient's blood pressure was essentially near goal.
Case 7	***Adequate.*** A thirty-one year old patient seen in medical three times during the review period for follow-up with asthma. On two occasions, there was no documentation found regarding control and clinical trend of asthma.
Case 9	***Adequate.*** A thirty-five year old patient seen for follow-up on knee pain and Emergency Room evaluation for febrile illness. During one of the visits, the provider prescribed Omeprazole, without medical indication for it. Additionally, there was no documentation on the progress note indicating a reason why the laboratory test, which was not medically necessary in a patient with no gastrointestinal (GI) symptoms, was ordered.
Case 11	***Inadequate.*** A fifty-two year old patient seen for history and physical (H&P) examination and for follow-up to H&P. During the H&P visit, the provider noted in assessment that the patient was diagnosed with COPD; however, the provider failed to address it further. Additionally, the provider prescribed Ranitidine without any diagnosis and Claritin when the patient had no symptoms. A month later during the follow-up visit, the provider at the patient's request prescribed Naprosyn for back pain; however, it was not medically necessary given a normal physical exam.
Case 13	***Inadequate.*** A forty-six year old patient seen for a spider bite, rash and elevated blood pressure. The services provided by the physician were deemed inadequate due to the following reasons: • During the December 2015 follow-up visit to RN's referral for CDCR Form 7362, *Health Care Services Request*, the provider failed to address the patient's elevated blood pressure of 166/99.

- During the March 2016 appointment, the patient was seen by the provider for a rash and expired medications. The provider prescribed an excessive dose of Diflucan for Tinea cruris. There was no documentation in the progress note indicating the patient was being started on Amlodipine and no reason noted why hydrocortisone cream and artificial tears were prescribed.
- In April 2016, the patient was seen in chronic care clinic for follow-up regarding hypertension and laboratory results. The provider failed to address an abnormal EKG test. There was no documentation in assessment of control and clinical trends of hypertension. Additionally, it is unknown how diagnoses of sickle cell trait and probable thalassemia were made when the patient's hemoglobin was within normal limits.

Case 14	***Adequate.*** A forty-six year old patient seen multiple times during the review period for various reasons. There was one minor deficiency noted during the patient's history and physical examination. The provider noted a scalp mass issue on the progress note; however, the provider failed to address it further.

The physician findings in this report and recommendations were based upon the observations made while touring the facility, interviews with medical staff, interview with Inmate Advisory Committee (IAC) inmates, and review of selected medical records. Following are some recommendations provided by CCHCS physician on how the provider's performance at SMCCF may be improved:

- Initiate use of eUHR immediately to review historical labs and notes. This information is key to reducing unnecessary blood work and repeat work up in general as well as decreasing medically unnecessary evaluations.
- Educate and orient the provider on CCHCS medical policies and procedures and California Code of Regulations, Title 15, pertaining to medical care.
- The provider is to start writing legibly or start dictating notes. The provider needs to supply adequate documentation of his medical decision making.
- The provider is to document rationale for diagnoses and plans, and perform exams on body systems related to diagnoses.
- Facility to keep a copy of CCHCS's InFocus guide in the clinic for PCP's reference as necessary. InFocus guide contains valuable information which can assist in providing appropriate and medically necessary clinical care in a correctional setting.
- Do not order medications not medically necessary or appropriate for patient's medical condition (e.g. Metformin without laboratory results, Lipitor without recent Lipid Panel results).
- Utilize the Chronic Care Guidelines provided by CCHCS. Topics to include diabetes management and hypertension management.
- Order laboratory tests and treatments based on evidence-based guidelines and consistent with California Title 15 regulations pertaining to medical care; utilize UpToDate, Choosing Wisely, and other resources to support the use of screening labs.
- Facility to complete frequent peer review of PCP's performance.
- Utilize CCHCS Health Care Compliance and Monitoring Audit Findings in Quality Improvement Projects.

PRIOR CRITICAL ISSUE RESOLUTION

The audit from March 2015 resulted in the identification of seven quantitative and six qualitative critical issues. On November 2, 2015, CCHCS auditors performed a Corrective Action Plan (CAP) Review where the previously identified critical issues were reviewed. At the time of the CAP Review, 9 of the 13 items were found to be resolved and 4 remained unresolved. One issue previously identified is no longer measured in the new audit instrument due to elimination of that question from the audit instrument. During the current audit, auditors found the remaining three issues resolved. Below is a discussion of each previous critical issue:

1. *(Formerly Question 2.8) - THE PATIENTS' WRITTEN REQUESTS FOR HEALTH CARE INFORMATION ARE NOT NOTED IN THE PROGRESS NOTES OF THE PATIENT MEDICAL FILES.*

   This specific requirement is no longer rated in the compliance portion of the Private Prison Compliance and Health Care Monitoring Audit; therefore, no compliance score is available.

2. *Question 5.1 (Formerly Question 5.1) - THE PATIENTS' CHRONIC CARE FOLLOW-UP VISITS ARE NOT CONSISTENTLY COMPLETED WITHIN THE 90-DAY OR LESS TIME FRAME, OR AS ORDERED BY THE PROVIDER.*

Prior Compliance	Current Compliance	Status
80.0%	93.3%	**Resolved**

   During the CAP Review, five inmate-patient medical records were reviewed and one was found non-compliant with this standard, equating to compliance rating of 80.0%. During the current audit, of the 30 patient medical records reviewed, two were non-compliant with this requirement. In one case, the PCP ordered a 90 day follow-up; however, the patient was not seen for 180 days. In another case, the auditor was unable to locate documentation in the eUHR that the chronic care visit took place on the date recorded on the monitoring log. This equates to 93.3% compliance. The findings show that SMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

3. *Question 7.3 (Formerly Question 7.1) - THE DIAGNOSTIC TEST RESULTS ARE NOT CONSISTENTLY BEING PROVIDED TO THE PATIENTS WITHIN THE SPECIFIED TIME FRAME.*

Prior Compliance	Current Compliance	Status
60.0%	88.9%	**Resolved**

   During the CAP Review, five inmate-patient medical records were reviewed for compliance; two were found non-compliant as patients were not provided with diagnostic test results within two days of facility's receipt of the results. This equated to 60.0% compliance. During the current audit, the auditor reviewed 18 patient medical records for compliance with this requirement. Two records were found non-compliant: one due to missing documentation of written notification of ultrasound results and the other one due to facility failing to provide the patient with written notification of the diagnostic test results within the required time frame. This equates to 88.9% compliance. As the facility met the established standard of 85.0% compliance, this critical issue is considered resolved.

4. *Question 10.1 (Formerly Question 14.2) - THE TREATING PROVIDER DOES NOT CONSISTENTLY DOCUMENT THAT EDUCATION REGARDING THE MEDICATION WAS PROVIDED TO THE PATIENT.*

Prior Compliance	Current Compliance	Status
80.0%	94.4%	**Resolved**

During the CAP Review, five inmate-patient medical records were reviewed and one was found non-compliant as it did not contain documentation that education regarding the medication was provided to the patient by the PCP. This equated to 80.0% compliance. The current audit findings reflect that of the 18 patient medical records reviewed, one was missing documentation of provider educating the patient on the newly prescribed medication. This equates to 94.4% compliance. As the facility met the established standard of 85.0% compliance, this critical issue is considered resolved.

NEW CRITICAL ISSUES

As a result of the current audit, there were 15 new critical issues identified. All of the new critical issues resulting from the quantitative review are addressed in the "Audit Findings – Detailed by Quality Indicator" section of this report.

CONCLUSION

The audit findings presented in this report encompass the evaluation of care provided by the facility to its patient population from December 1, 2015 through May 31, 2016. The facility's overall performance during this time frame was rated *adequate*. Of the 16 quality indicators evaluated, CCHCS found six *proficient*, seven *adequate*, and three *inadequate* (see Executive Summary Table on page 4). Although the facility has resolved all of the outstanding critical issues, 15 new critical issues were identified during the current audit. It should be noted that the majority of the deficiencies mentioned in this report are easily correctable and are within the management's scope of control to ensure compliance.

Some of the specific issues that raise the audit team's concern based on the current findings are:

- patients not receiving their KOP medications timely or as ordered by provider,
- nursing staff not administering the prescribed medication as ordered by PCP,
- provider prescribing medications that are not medically necessary,
- facility not completing timely peer review of provider,
- missing Chief's and Health Services Administrator's signatures on the EMRRC meeting minutes,
- missing and/or incomplete documentation in the patients' medical records,
- provider's illegible handwriting and inadequate documentation.

These are some of the more critical issues that were identified during the current audit which, if left unaddressed, may create barriers preventing the patients from receiving an adequate level of health care. The audit team recommended the executive team 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.

At the conclusion of the onsite visit on Thursday, June 30, 2016, the audit team met with the Chief of Corrections, the day shift RNs, the facility's physician, and management staff to present the findings of the audit. This meeting afforded the audit team an opportunity to provide feedback and recommendations regarding the case review, the chart review and the onsite findings. The facility's management and health care staff were receptive and open to the findings presented by the audit team. SMCCF should be commended on their resolution of the four outstanding critical issues from the November 2015 CAP Review. During the exit meeting, facility management and health care staff reiterated their dedication to continuing to provide quality health care to the California patients in their care.

PATIENT INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the patient population, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. This is accomplished via interview of all the ADA patients housed at the facility, the IAC executive body and a random sampling of patients housed in general population and administrative segregation units. The results of the interviews conducted at SMCCF 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 visit, the audit team interviewed 10 IAC representatives and one DPP patient.

1. Regarding questions 1 through 4 – All interviewed patients were aware of the sick call process and had ready access to the forms, if needed. The patients claimed the RN picks up the CDCR Forms 7362, *Health Care Services Request*, daily and sees the patients within one to two business days. Out of the 10 IAC representatives interviewed, four have utilized the sick call

process within the past six months. When the auditor enquired regarding their access to specialty services, one of the patients stated that approximately eight months ago (November 2015) the provider saw him in medical and made a referral to a specialist for liver treatment. In mid June 2016, the patient put in another request to be seen by provider for the same complaint; however, at this time the provider ordered laboratory tests. As of the date of the onsite audit, the patient has not been seen by the specialist or has heard back from the provider regarding the status of the referral. This was brought to the provider and management's attention during the exit meeting. The facility was encouraged to develop a system where provider referrals to specialty services could be tracked and completed in a timely manner.

Additionally, several representatives of the IAC claimed that custody staff sometimes would deny patients access to the clinic for urgent/emergent services. This concern was brought to the attention of the Chief to look into and ensure the patient population at SMCCF is not denied access to medical care at any time. The audit team requested the IAC present these issues and concerns at their monthly meetings with the Chief so that if the claim is proven valid, it could be resolved by the Chief expediently.

2. Regarding questions 5 through 8 – Majority of the interviewed patients were not aware of the health care appeal process. After the auditor mentioned that it was the pink forms in their dorms, one of the patients stated that these forms were just made available within the past two days. Two days prior to this interview with the IAC, during the tour of the facility, the audit team inspected all the housing units and checked every dorm to ensure the sick call and health care appeal forms were readily available to the patient population. The audit team found the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals*) forms inside the locked cabinet in six of the eight dorms. The facility was instructed to remove the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* from the locked cabinet and place them next to the CDCR Forms 7362, *Health Care Services Request*, for patients to access at any time. The auditor explained the health care appeal process to IAC representatives and informed the patients that this information was also available to them in the patient orientation handbook/manual they have received upon arrival at the facility. This issue was brought to the management staff's attention, who immediately took steps to resolve the issue.

3. Regarding questions 9 through 21 - At the time of the onsite audit, there was only one ADA patient housed at SMCCF. There were no negative responses or issues expressed by this patient. On the contrary, the patient was quite pleased and content with the health care services that were provided to him by SMCCF medical staff. The patient indicated he has access to medical whenever he has any concerns regarding his disability.