December 27, 2018

Cynthia Armant, Warden
Kimberlee Newmire-Ford, Health Services Administrator
Desert View Modified Community Correctional Facility
10450 Rancho Road
Adelanto, CA 92301

Dear Warden Armant and Ms. Newmire-Ford,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite Private Prison Compliance and Health Care Monitoring Limited Review audit at Desert View Modified Community Correctional Facility (DVMCCF) on October 2 and 4, 2018. The purpose of this audit was to examine the facility's progress in resolving inadequate components and critical issues identified during the March 2018 annual audit.

On December 21, 2018, a draft report was provided to allow you the opportunity to review and dispute any findings presented in the report. On December 27, 2018, you submitted a response accepting the findings.

Attached is the final limited review audit report. The scope of the limited review included a re-examination of three components, Component 6, *Emergency Services and Community Hospital Discharge*, Component 8, *Medical/Medication Management,* Component 10, *Specialty Services,* and 19 critical issues. As a result of the audit, one component received a passing score and ten critical issues were found resolved.

Component 6, *Emergency Services and Community Hospital Discharge*, received an overall compliance score of 79.4%, which is a slight increase of 0.7 percentage points from the 78.7% received during the annual audit. Auditors found the facility was unable to resolve the prior critical issues for this component.

Component 8, *Medical/Medication Management*, received an overall component score of 93.0%, which is an increase of 17.5 percentage points from the 75.5% compliance score received during the annual audit. Auditors found both critical issues previously identified for this component resolved.

Component 10, *Specialty Services*, received an overall component score of 68.5%, which is a decrease of 4.2 percentage points from the 72.7% compliance score received during the annual audit. Auditors found one of the three critical issues previously identified critical issues resolved.

The critical issues from the remainder of the components totaled 13, of which, auditors found seven were resolved. The facility should work diligently to resolve the remainder of the nine critical issues still remaining unresolved.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation during this audit. Should you have any questions or concerns, you may contact Anastasia Bartle, Program Manager, Private Prison Compliance and Monitoring Unit, Field Operations, Corrections Services, CCHCS, at (916) 691-4921 or via email at Anastasia.Bartle@cdcr.ca.gov.

Sincerely,

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

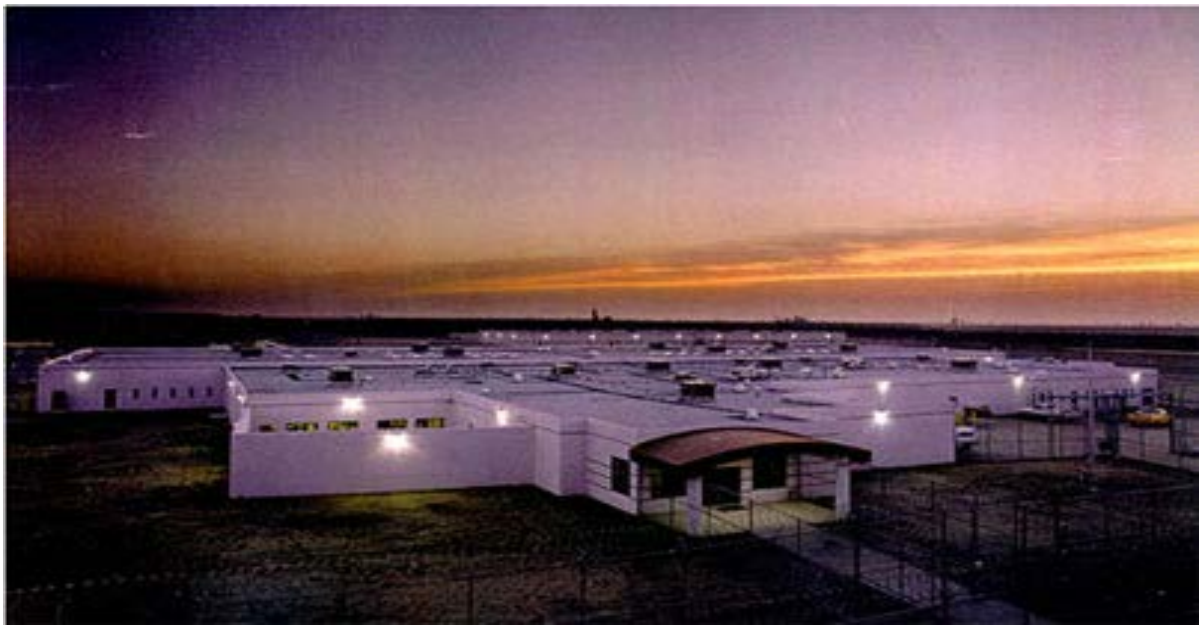
Enclosure

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

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

# PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

## Limited Review



## Desert View Modified

## Community Correctional Facility

October 2-4, 2018

# TABLE OF CONTENTS

## DATE OF REPORT

**December 27, 2018**

## INTRODUCTION

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

As one of several means to ensure the prescribed health care standards are provided, CCHCS staff developed a tool to evaluate and monitor the delivery of health care services provided at the contracted facility through a standardized audit process. The process is divided into phases; a remote phase and an onsite phase. The remote phase consists of a review of various documents obtained from the facility including health records, monitoring logs, staffing rosters. The onsite phase involves staff and patient interviews and a tour of all health care service points within the facility.

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

## EXECUTIVE SUMMARY

An annual health care monitoring audit was conducted at Desert View Modified Community Correctional Facility (DVMCCF) on March 6 through March 8, 2018. The audit review period was October 2017 through January 2018. The patient population at the time was 692 and the facility's budgeted capacity was 700[1]. The facility received an overall compliance score of 86.6% (*Adequate*) based on the scores compiled from each of the 14 components. Five components received a rating of *Inadequate*[2], and 19 critical issues were identified. Because of failing one or more components, a limited review audit was scheduled seven months following the annual audit.

The PPCMU audit team conducted a limited review audit at DVMCCF on October 2 through 4, 2018. A nursing onsite audit was conducted November 26 through 27, 2018. The audit review period was April

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

[2] Two of the five components, (14. *Quality of Nursing Performance* and 15. *Quality of Physician Performance*) are only reviewed during the annual audit. Subsequently, these two components are not part of this limited review.

through July 2018. Per CDCR's Weekly Population Count report, dated September 28, 2018, the patient population was 649 and the facility's budgeted capacity was 683. The audit team consisted of the following personnel:

R. Delgado, Medical Doctor, Retired Annuitant
S. Fields, Nurse Consultant, Program Review (NCPR) Retired Annuitant
S. Carroll, Health Program Specialist
K. Srinivasan, Health Program Specialist

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

- Three components, inclusive of both clinical case reviews and quantitative review
  - Component 6, *Emergency Services and Community Hospital Discharge*
  - Component 8, *Medical/Medication Management*
  - Component 10, *Specialty Services*
- Nineteen critical issues identified during the March 2018 audit

The results of the limited review indicate the facility increased its compliance score for Component 6 and Component 8 by 0.7 and 17.5 percentage points respectively. There was no improvement to Component 10, which decreased 4.2 percentage points. A comparison of the component scores between the March and October 2018 audits is listed below.

## Executive Summary Table

| Component | Audit Type | Case Review | | Overall Case Review | Quantitative Review | Overall Component |
|---|---|---|---|---|---|---|
| | | Nurse | Provider | | | |
| 6. Emergency Services and Community Hospital Discharge | A | 63.6% | 87.5% | 75.6% | 85.0% | 78.7% *Inadequate* |
| | LR | 69.2% | 88.9% | 79.1% | 80.0% | 79.4% *Inadequate* |
| | +/- | +5.6 | +1.4 | +3.5 | -5.0 | +0.7 |
| 8. Medical/Medication Management | A | 84.6% | 50.0% | 67.3% | 91.9% | 75.5% *Inadequate* |
| | LR | 95.5% | 85.0% | 90.2% | 98.6% | 93.0% *Proficient* |
| | +/- | +10.9 | +35.0 | +22.9 | +6.7 | +17.5 |
| 10. Specialty Services | A | 46.2% | 100.0% | 73.1% | 71.9% | 72.7% *Inadequate* |
| | LR | 60.9% | 69.6% | 65.2% | 75.0% | 68.5% *Inadequate* |
| | +/- | +14.7 | -30.4 | -7.9 | +3.1 | -4.2 |

The audit team found 10 of the 19 critical issues identified during the annual audit were successfully resolved. No new critical issues were identified.

| Component | | Critical Issues | Resolved | Unresolved | New Critical Issues |
|---|---|---|---|---|---|
| 1. | Administrative Operations | 1† | 1† | 0 | 0 |
| 2. | Internal Monitoring & Quality Management | 7† | 2 | 5† | 0 |
| 4. | Access to Care | 2† | 2† | 0 | 0 |
| 6. | Emergency Services & Community Hospital Discharge | 1 | 0 | 1 | 0 |
| 7. | Initial Health Assessment/HC Transfer | 2 | 2 | 0 | 0 |
| 8. | Medical/Medication Management | 2 | 2 | 0 | 0 |
| 10. | Specialty Services | 3† | 1† | 2† | 0 |
| 11. | Preventive Services | 1 | 0 | 1* | 0 |
| | **Totals:** | **19** | **10** | **9** | **0** |

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

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

## IDENTIFICATION OF CRITICAL ISSUES

The table below reflects all quantitative analysis standards in which the facility's compliance fell below acceptable compliance levels. The table also includes any qualitative critical issues or concerns identified by the audit team which rise to the level at which they have the potential to adversely affect patients' access to health care services. During the annual audit, 19 critical issues were identified. During the re-audit, auditors found 10 of the 19 critical issues resolved, and 9 unresolved. The table below lists the nine unresolved critical issues from the prior audits.

| **Critical Issues – Desert View Modified Community Correctional Facility** | |
|---|---|
| Question 2.4 | The facility does not submit all weekly and monthly monitoring logs by the scheduled date per PPCMU program standards. ***This is an unresolved critical issue from the March 2018 audit.*** |
| Question 2.6 | The facility does not accurately document all data on the Specialty Services Monitoring Log. ***This is an unresolved critical issue from the October 2016 audit.*** |
| Question 2.7 | The facility does not accurately document all data on the Hospital/Emergency Department/Hub Emergency Services Monitoring Log. ***This is an unresolved critical issue from the March 2018 audit.*** |
| Question 2.13 | The facility does not process institutional level health care grievances within the specified time frame. ***This is an unresolved critical issue from the February 2016 audit.*** |
| Question 6.1 | The facility's Registered Nurse (RN) does not consistently review the patient's discharge plan/instructions upon the patient's return from a community hospital discharge. ***This is an unresolved critical issue from the March 2018 audit.*** |
| Question 10.3 | The facility RN does not notify the facility primary care provider (PCP) of any immediate medication or follow-up requirements provided by the specialty consultant upon the patient's return from the specialty services appointment. ***This is an unresolved critical issue from the March 2018 audit.*** |
| Question 11.2 | The facility does not consistently offer an influenza vaccination to all patients for the most recent influenza season. ***This is an unresolved critical issue from the March 2018 audit.*** |
| Qualitative Critical Issue #1 | The facility does not consistently document accurate health care grievance response due dates on the health care grievance log. ***This is an unresolved critical issue from the March 2018 audit, Qualitative Critical Issue #2.*** |
| Qualitative Critical Issue #2 | The facility's procedure to obtain approvals for Specialty Services consultations and procedures does not follow the IMSP&P guidelines. ***This is an unresolved critical issue from the March 2018 audit, Qualitative Critical Issue #4.*** |

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

## LIMITED REVIEW – FULL COMPONENT AUDIT

During the March 2018 annual audit, five components received an overall rating of *Inadequate*. Per the audit methodology contained in the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide (Revised November 2017)*, all sections of these components are re-examined as part of the limited review. Component 14, *Quality of Nursing Performance,* and Component 15, *Quality of Physician Performance*, are reviewed annually and therefore are not part of this limited review audit. Below are the findings for Components 6, 8, and 10.

## 6 – EMERGENCY SERVICES AND COMMUNITY HOSPITAL DISCHARGE

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

***Case Review Score:*** *79.1%*
***Quantitative Review Score:*** *80.0%*

***Overall Score: 79.4%***

The auditors evaluate the emergency medical response system and the facility's ability to provide effective and timely responses. The clinician auditors assess the timeliness and adequacy of the medical care provided based on the patient's emergency situation, clinical condition, and need for a higher level of care.

During the annual audit, the facility received an overall compliance score of 78.7% (*Inadequate*). As a result of the limited review, DVMCCF achieved an overall compliance score of 79.4% (*Inadequate*). Specific findings for the nurse and physician case reviews and the quantitative review are documented below.

### Case Review Results

During the annual audit, the facility received an overall case review score of 75.6% (*Inadequate*). During the limited review, the facility received a score of 79.1% (*Inadequate*), an increase of 3.5 percentage points.

**Nurse Case Reviews**

During the annual audit, the facility received a compliance score of 63.6% (*Inadequate*). For the limited review, the facility received a compliance score of 69.2% (*Inadequate*). This is an increase of 5.6 percentage points. The NCPR auditor reviewed 13 nursing encounters and identified four deficiencies. The specific deficiencies identified during the limited review are:

- **In Case 16,** on April 24, 2018, there was no documentation in the patient's electronic health record that nursing staff performed an assessment of the patient prior to the patient transferring to a community emergency department.

- **In Case 17,** on June 30, 2018, at approximately 0615 hours, the patient was seen for complaints of feeling weak, dizzy, numbness in left arm, and high blood pressure. The nursing staff did not refer the patient to the PCP immediately (STAT). The nursing staff did not monitor the patient's blood pressure every 15 minutes and did not document if left arm weakness persisted. Nursing staff performed an electrocardiogram[3] (EKG) on the patient; however, the time of the EKG was documented at 0523 hours, approximately 52 minutes prior to the patient being seen. Based on the patient's symptoms, he should have been immediately referred to the PCP and blood pressure monitored every 15 minutes. The auditors were unable to determine the actual time the EKG was performed. Instead of being seen by the PCP immediately, the patient was returned to the housing unit with a follow-up appointment with the PCP the following week.
- **In Cases 18** and **19,** the RN completed a face-to-face assessment upon the patients' return to the facility from the hub institution following their discharge from the community hospital. However, the RN's progress notes did not clearly indicate the RN reviewed the discharge instructions and/or any new orders.

**Physician Case Reviews**

During the annual audit, the facility received a compliance score of 87.5%. For the limited review, the facility received a compliance score of 88.9%, an increase of 1.4 percentage points. The physician auditor reviewed nine provider encounters and identified one deficiency. The specific finding of the deficiency is listed below:

- **In Case 2**, the patient was sent out to a community hospital for chest pain on April 22, 2018. On April 25, 2018, the patient returned to DVMCCF from the hub institution following discharge from a community emergency department. There was no documentation to confirm the PCP interpreted the EKG performed on April 22, 2018, and the PCP failed to conduct a physical examination on the patient upon return to DVMCCF.

## Quantitative Review Results

During the annual audit, the facility received a quantitative compliance score of 85.0% (*Adequate*) with one critical issue identified. During the limited review, all four questions for this component were re-evaluated resulting in a score of 80.0% (*Adequate*) with the critical issue left unresolved. This is a decrease of five percentage points from the previous score. Of the four questions reviewed, three were rated *Proficient* and one was rated *Inadequate*. Discussion of this component's critical issue is documented below.

During the annual audit, the NCPR auditor identified the facility's nursing staff failed to consistently review the discharge plans/instructions of patients returning from a community hospital (Question 6.1). This resulted in a compliance score of 40.0%. During the limited review, the NCPR auditor reviewed ten patient electronic health records and identified nursing staff did not review the discharge plans/instructions for eight patients. This resulted in a compliance score of 20.0%, a decrease of 20 percentage points from the annual review. This critical issue remains unresolved.

[3] Electrocardiogram is a paper or digital recording of the electrical signals in the heart. It is also called an EKG.

## 8 – MEDICAL/MEDICATION MANAGEMENT

***Case Review Score:*** *90.2%*
***Quantitative Review Score:*** *98.6%*
***Overall Score****: 93.0%*

For this component, the clinicians assess the facility's health care staff performance to determine whether appropriate and medically necessary care was provided to the patient population per the nursing and physician scope of practices and clinical guidelines established by the department. This includes, but is not limited to, the following: proper diagnosis, appropriateness of medical/nursing action, and timeliness and efficiency of treatments and care provided related to the patient's medical complaint. The clinicians also assess the facility's process for medication management which includes: timely filling of prescriptions, appropriate dispensing of medications, appropriate medication administration, completeness in documentation of medications administered to patients, and appropriate maintenance of medication administration records. This component also factors in the appropriate storing and maintenance of refrigerated drugs, vaccines, and narcotic medications.

During the annual audit, the facility received an overall compliance score of 75.5% (*Inadequate*). During the limited review, the facility received a score of 93.0%, an increase of 17.5 percentage points. Specific findings for the nurse and physician case reviews and the health record review are documented below.

### Case Review Results

During the annual audit, the facility received an overall case review compliance score of 67.3% (*Inadequate*). During the limited review, the facility received a score of 90.2% (*Proficient*), an increase of 22.9 percentage points.

**Nurse Case Reviews**

During the annual audit, the facility received a compliance score of 84.6%. For the limited review, the facility received a compliance score of 95.5%, an increase of 10.9 percentage points. The NCPR auditor reviewed 111 nursing encounters and identified five deficiencies. These deficiencies are all related to one case, which is described below:

- **In Case 21,** on five separate occasions the NCPR auditor was unable to find a Medication Administration Record (MAR) documenting receipt of methotrexate. Nursing staff should be documenting the administration of medication on the MAR.

**Physician Case Reviews**

During the annual audit, the facility received a compliance score of 50.0%. For the limited review, the facility received a compliance score of 85.0%, a significant increase of 35 percentage points. The physician auditor reviewed 40 provider encounters and identified six deficiencies:

- **In Case 2,** two deficiencies were identified. On June 19, 2018, the patient was seen by the PCP for a chronic care appointment to discuss hypertension and lipid abnormalities. The PCP's documentation reported the lipids as "good control;" however, the actual lipid values were not

documented. There was also no documentation the PCP completed an American College of Cardiology[4] 10-year Heart Risk Assessment to determine the need for the patient's aspirin prescription. On June 25, 2018, the patient was seen by the PCP for complaints of lightheadedness and pain. The patient reported a pain scale of 4/10. The PCP's progress note did not document orthostatic vitals nor was the patient's pain addressed. Orthostatic vitals are required to be taken for complaints of lightheadedness.

- **In Case 5,** the patient was referred to the community hospital emergency department on April 25, 2018, by the PCP for headaches and emesis (vomiting). There was no documentation in the patient's electronic health record of the physician evaluating the patient or the patient's status prior to referring patient to the emergency department. In an emergency situation, a physician progress note can be written after the patient is transferred to the emergency department.
- **In Case 7,** the patient was seen by the PCP on May 23, 2018, for complaints of impaired distant vision. There was no documentation in the PCP's progress note indicating the PCP performed a vision test or physical examination of the patient before referring to ophthalmology.
- **In Case 9,** the patient was seen by the PCP on July 6, 2018, for a follow up appointment regarding the patient's arthritis medication methotrexate. The patient's arthritis medication expired three weeks prior to the visit. Methotrexate is a chronic care medication for arthritis and the PCP should have renewed the prescription prior to expiration or documented on a progress note the reason of the non-renewal.
- **In Case 12,** on June 26, 2018**,** the patient was transferred to the hub institution for partial toenail removal. On July 16, 2018, the patient was seen by the PCP for a request to be tested for diabetes. The patient was seen daily for dressing changes to the affected toe. During the period the patient was receiving the daily dressing changes, the patient was seen by the PCP for other medical issues. The PCP did not document the evaluation and condition of the patient's toe during these encounters.

**Recommendation:**

- The PCP should include the review of prior health care issues during all patient encounters.

## Quantitative Review Results

During the annual audit, the facility received a score of 91.9% (*Proficient*) with two critical issues. During the limited review, the facility received a score of 98.6% (*Proficient*), an increase of 6.7 percentage points. Both critical issues are resolved. A discussion of this component's findings is documented below.

During the annual audit, the facility did not consistently administer chronic care medications within their required time frames (Question 8.1), resulting in a compliance score of 43.8%. During the limited review, the auditor's review of 16 patient health records showed all patients were provided their chronic care medications within the required time frames, resulting in a compliance score of 100%. This is a significant increase of 56.2 percentage points from the previous score. This critical issue is resolved.

[4] American College of Cardiology – is a nonprofit medical association established in 1949. The mission of this organization is to transform cardiovascular care and to improve heart health.

During the annual audit, the facility's patients were not administered their newly prescribed medications as ordered by the PCP (Question 8.7), resulting in a compliance score of 75.0%. During the limited review, the NCPR auditor reviewed 16 patient health records and determined all patients received their newly prescribed medications as ordered. This critical issue is resolved.

## 10 – SPECIALTY SERVICES

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

***Case Review Score:*** *65.2%*
***Quantitative Review Score:*** *75.0%*

***Overall Score: 68.5%***

During the annual audit, the facility received an overall compliance score of 72.7% (*Inadequate*). The limited review revealed DVMCCF's performance decreased 4.2 percentage points since the annual audit, resulting in an overall compliance score of 68.5% (*Inadequate*). Specific findings for the nurse and physician case reviews and the quantitative review are documented below.

### Case Review Results

During the annual audit, the facility received a case review compliance score of 73.1% (*Inadequate*). During the limited review, the facility received a score of 65.2% (*Inadequate*), a decrease of 7.9 percentage points.

**Nurse Case Reviews**

During the annual audit, the facility received a compliance score of 46.2%. For the limited review, the facility received a compliance score of 60.9%, an increase of 14.7 percentage points. The NCPR auditor reviewed 23 nursing encounters and identified nine deficiencies:

- **In Cases 21, 22, 23, and 24**, there were seven encounters where the auditor did not find documentation of nursing staffs' review of new orders or instructions from the specialty consultant upon the patient's return.
- **In Case 21**, on April 6, 2018, the PCP ordered an urgent referral to Gastroenterology for a colonoscopy. The patient was seen 18 days later on April 24, 2018. Per IMSP&P Volume 4, Chapter 8, *Outpatient Specialty Services*, high priority consultations or procedures shall be provided within 14 calendar days of PCP order.
- **In Case 25**, the patient refused to receive physical therapy at the hub institution. Although nursing staff completed a refusal form, they did not specify what procedure was refused. Additionally, nursing staff did not include their title on the refusal form.

**Physician Case Reviews**

During the annual audit, the physician auditor reviewed three provider encounters and found no deficiencies resulting in a compliance score of 100%. For the limited review, the facility received a compliance score of 69.6%, a significant decrease of 30.4 percentage points. The physician auditor reviewed 23 provider encounters and identified seven deficiencies:

- **In Case 7**, patient was seen by the PCP for a sprained ankle on April 9, 2018, and again on April 12, 2018, for a follow-up by the PCP. The PCP's progress note documented "Referral to Ortho for evaluation and recommendation." On the same day, the patient was sent to the hub institution's Triage and Treatment Area for evaluation. There is no documentation in the health record the hub Chief Physician and Surgeon (CP&S) reviewed DVMCCF PCP's orthopedic referral. Transportation of the patient to the hub for an RFS determination by a mid-level provider is not cost effective and may impair access to appropriate care.
- **In Case 8,** the patient was seen on April 25, 2018, via telemedicine by an ear, nose, and throat (ENT) specialist for complaint of hearing loss and ear drainage persistent for eight months. The consultation report did not document an ear examination. On May 1, 2018, the patient was seen by the facility's PCP to review the findings from the specialty service appointment. The PCP's progress note lacked documentation of an ear exam.
- **In Case 9,** on April 6, 2018, the facility's PCP completed an RFS regarding the patient's rectal bleeding. There was no documentation in the patient's health record the RFS was reviewed by the hub CP&S, nor was there documentation of the DVMCCF PCP's follow-up on the referral. On April 24, 2018, the patient was seen by the DVMCCF PCP to discuss findings from a rheumatology consultation. At the time, there was no documentation of follow-up or discussion regarding the colonoscopy RFS. The patient was seen numerous times by the PCP for his chronic care condition and the PCP did not document discussion or follow-up on the outstanding colonoscopy RFS.
- **In Case 10,** the patient was seen at the hub institution on June 5, 2018, for a fractured metatarsal on the right foot. An urgent orthopedic RFS was generated and approved on June 5, 2018. The urgent RFS was not completed until nearly a month later on July 2, 2018. Urgent referrals are required to be completed within 14 days of the PCP's order per IMSP&P, Volume 4, Chapter 8, *Outpatient Specialty Services*.
- **In Case 12,** after returning from an optometry consultation on July 5, 2018, the patient was seen by the PCP on July 6, 2018, to discuss the results of the optometry consult. At the time, the PCP did not document evaluation of the patient's toe after partial toenail removal on June 26, 2018.
- **In Case 15,** the patient was seen by the PCP on July 20, 2018, for a five year history of a bunion. The PCP did not document the reason the referral was medically necessary or document if the referral was to consider surgery or non-surgical approach. The PCP's progress note was sparse and inadequate. The hub institution's provider documented the patient did not want surgical intervention, but wanted wider shoes. The referral to podiatry was inappropriate and unnecessary.

## Quantitative Review

During the annual audit, the facility received a quantitative compliance score of 71.9% (*Inadequate*) with one quantitative and two qualitative critical issues identified. For the limited review, this component received a score of 75% (*Inadequate)*, an increase of 3.1 percentage points. Of the four questions reviewed, three received a score of 100% and one received a score of 0.0%. One qualitative and one quantitative critical issue remain unresolved and one qualitative critical issue was resolved. Discussion of this component's qualitative and quantitative critical issues is documented below.

During the annual audit, the NCPR identified the facility RNs do not notify the facility PCP of any immediate medication(s) or follow up appointments recommended by the specialty consultant upon the patient's return from a specialty services appointment (Question 10.3). This resulted in a compliance score of 0.0%. During the limited review, the NCPR auditor reviewed 16 patient electronic health records and found no improvement. The RNs did not notify the PCP, resulting in a score of 0.0% compliance. This critical issue remains unresolved.

During the annual audit, the physician auditor found that when the facility PCP initiates an RFS, the hub institution health care staff request the patient be transferred and re-evaluated at the hub prior to approving the RFS. This drastically delayed the RFS process which resulted in a qualitative critical issue (Qualitative Critical Issue #4). During the limited review, the physician auditor identified this process was still in place during the audit review period. On September 19, 2018, the physician auditor reached out to the facility and requested they begin faxing new RFS's directly to the utilization management nurse at the hub for approval rather than having the patient transferred to the hub for a second evaluation. Because the change in the RFS process took place outside the audit review period, this critical issue remains unresolved and will be re-evaluated during subsequent audits.

During the annual audit, the auditing physician found dictated consultations were infrequently provided to DVMCCF (Qualitative Critical Issue #5). During the limited review, the physician auditor's review of offsite specialty appointments revealed the typed consultations are being provided timely in the majority of cases. This qualitative critical issue is now resolved.

## LIMITED REVIEW – PARTIAL COMPONENT AUDIT

The annual audit conducted in March 2018 resulted in one inadequate case review rating and the identification of 19 critical issues. During the limited review, auditors found the case review rating was adequate and eleven critical issues resolved. One critical issue was unable to be rated. The facility's progress in resolving the critical issues associated with Components 6, 8, and 10 is discussed in the preceding sections, Limited Review – Full Component Audit. The remainder of the critical issues are discussed below.

# 1. ADMINISTRATIVE OPERATIONS

### Quantitative Review

During the annual audit, the facility achieved a quantitative score of 97.5% (*Proficient)* with one critical issue identified.

1. The facility medical staff do not log into the electronic Unit Health Record System (e-UHR) besides accessing Cerner electronic Health Record System (EHRS). This resulted in the staff losing access to both e-UHR and EHRS requiring password resets and/or account reactivation. (Qualitative Critical Issue #1)

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

This critical issue was identified during the March 2018 annual audit. The facility's PCP was able to log in, but the auditors found the nursing staff had lost access due to inactivity. This resulted in a qualitative critical issue. While conducting the onsite portion of the limited review, the auditors found all nursing staff could access the EHRS thus resolving this qualitative critical issue.

Although outside the scope of the limited review and not rated as part of this audit, auditors noted the PCP lost access to EHRS due to inactivity. The PCP stated he stopped accessing the EHRS after the conclusion of the annual audit. The PCP relies on nursing staff to provide him hard copies of the patient files for all patient encounters. The auditors emphasized the importance of accessing the EHRS, but the PCP said he plans to retire in December 2018 and has no interest in accessing EHRS.

# 2. INTERNAL MONITORING & QUALITY MANAGEMENT

### Quantitative Review

During the annual audit, the facility received a quantitative score of 83.3% (*Adequate*) with seven critical issues identified.

1. The Quality Management Committee (QMC) meeting minutes are not consistently signed and approved by the facility's Warden or designee. (Question 2.1)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 75.0% | 100.0% | **Resolved** |

During the annual audit, the NCPR auditor reviewed four QMC meeting minutes and identified one of the meeting minutes was not approved or signed by the Warden or designee. During the limited review, the NCPR auditor reviewed four QMC meeting minutes and identified all the meetings minutes were signed by the Warden or a designee. This critical issue is now resolved.

2. The facility did not submit all weekly and monthly monitoring logs by the scheduled date per PPCMU program standards. (Question 2.4)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 64.5% | 61.3% | **Unresolved** |

During the annual audit, the facility did not timely submit the weekly logs for six weeks and monthly logs were not submitted timely for two months. During the limited review, the weekly logs were not submitted timely for six of the 18 weeks and the monthly logs were not submitted timely for three of four months. This critical issue remains unresolved.

3. The facility does not accurately document all the data on the Sick Call Monitoring Log. (Question 2.5)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 72.2% | 94.1% | **Resolved** |

During the annual audit, 18 entries on the Sick Call Monitoring Log were reviewed and five entries contained incorrect CDCR numbers, incorrect names, and/or incorrect identification of the chief complaint. During the limited review, 15 of the 16 entries reviewed were accurate. This critical issue is resolved.

4. The facility does not accurately document all the data on the Specialty Services Monitoring Log. (Question 2.6)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 77.8% | 71.4% | **Unresolved** |

During the annual audit, 18 entries on the Specialty Care Monitoring Log were reviewed and four entries contained incorrect CDCR numbers, incorrect names, and/or incorrect identification of the chief complaint. During the limited review, 14 entries were reviewed and four entries contained wrong CDCR numbers and missing or incorrect dates. This critical issue remains unresolved.

5. The facility does not accurately document all the data on the Hospital/Emergency Department/Hub Emergency Services Monitoring Log. (Question 2.7)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 68.8% | 75.0% | **Unresolved** |

During the annual audit, 16 entries on the Hospital/Emergency Department/Hub Emergency Services Monitoring Log were reviewed and four entries contained incorrect CDCR numbers, incorrect names, and/or incorrect identification of the chief complaint. During the limited review, 12 entries were reviewed and three entries contained wrong CDCR numbers and incorrect dates on the log. This critical issue remains unresolved.

6. The facility does not process institutional level health care grievances within the specified time frames. (Question 2.13)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 61.5% | 40.0% | **Unresolved** |

During the annual audit, auditors reviewed 18 grievances and found five grievances were not completed within the 45 day time frame. During the limited review, 17 health care grievances were reviewed and nine were found deficient; seven were not reviewed timely by the RN and two were withdrawn with no reason. This critical issue remains unresolved.

7. The facility does not consistently document the accurate health care grievance response due dates on the health care grievance log. (Qualitative #2)

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

During the annual audit, the HPS auditor provided information to the HSA on how to calculate the due dates accurately so the facility could meet the 45-day time frame requirement for processing institutional level health care grievances. During the limited review, the auditors found due dates were past the 45-day time frame. This qualitative critical issue remains unresolved.

# 4. ACCESS TO CARE

### Nurse Case Review

During the annual audit, the NCPR auditor reviewed 200 nursing encounters and identified 59 deficiencies, resulting in a compliance score of 70.5%. For the limited review, the NCPR auditor reviewed 58 nursing encounters and identified seven deficiencies resulting in a score of 87.9%. This is an increase of 17.4 percentage points. The specific deficiencies identified during the limited review are:

- **In Cases 16, 23, and 24,** the nursing staff did not complete the CDCR Form 7362, *Health Care Services Request,* when the patient was unable to complete the form. If the patient is unable to complete a CDCR Form 7362, nursing staff is required to complete the form and state the reason why it could not be completed by the patient. There was one example of this found by the NCPR auditor in Cases 16 and 24, and two for Case 23.
- **In Case 17,** the NCPR auditor identified three deficiencies. The patient was seen during nursing sick call on May 31, June 12, and July 25, 2018. For all three encounters, there was no nursing documentation in the health record of an objective nursing assessment.

### Quantitative Review

During the annual audit, the facility received a quantitative review score of 98.5% (*Proficient*) with two critical issues identified.

1. The facility utilizes the Daily Huddle form inappropriately by not filing in information in advance of the Daily Care Team Huddles. Instead, staff complete the form retrospectively throughout the day. (Qualitative #3)

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

During the annual audit, the NCPR auditor discovered the facility's medical staff were not utilizing the required "huddle script." The NCPR auditor provided the HSA with the required "huddle script." During the limited review, the auditors reviewed the facility's clinical team for appropriate morning huddles. The auditors observed DVMCCF performing a proper huddle that appropriately gathered information prior to the huddle and accurately utilized the daily "huddle script." This qualitative critical issue is now resolved.

2. The facility health care staff do not consistently document effective communication (EC) was established during patient encounters. (Qualitative #6).

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

During the annual audit, the physician auditor found that the EC stamp was not consistently used to document patient encounters during the audit review period. During the limited review, the physician auditor observed the facility is consistently utilizing the EC stamp. This qualitative critical issue is now resolved.

## 7. INITIAL HEALTH ASSESSMENT/HEALTH CARE TRANSFER

### Quantitative Review

During the annual audit, the facility received a quantitative review score of 92.4% (*Proficient*) with two critical issues identified.

1. The facility RN does not consistently document an assessment of each question that is answered "yes" by the patient on the *Initial Intake Screening* Form (CDCR Form 7277/7277 A). (Question 7.2)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 72.7% | 100.0% | **Resolved** |

During the annual audit, the NCPR auditor reviewed 11 patient electronic health records and found three records deficient. In each instance, the Licensed Vocational Nurse (LVN) documented

the assessment of the patient instead of an RN. During the limited review, the NCPR auditor reviewed seven patient electronic health records and found the facility's RN documented the assessment. This critical issue is now resolved.

2. The facility does not consistently refer patients to the appropriate provider based on the RN's disposition. (Question 7.3)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 66.7% | 100.0% | **Resolved** |

During the annual audit, the NCPR auditor reviewed the electronic health records of 12 patients referred to the PCP and found three were referred by the LVN and not an RN. During the limited review, the NCPR auditor reviewed 12 electronic health records of patients referred to the PCP and found all patients were seen within the required time frame. This critical issue is now resolved.

## 11. PREVENTIVE SERVICES

### Quantitative Review

During the annual audit, the facility received a quantitative review score of 89.7% (*Adequate*) with one critical issue identified.

1. The facility does not consistently offer an influenza vaccine to all patients for the most recent influenza season. (Question 11.2)

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 69.2% | N/A | **Unresolved** |

During the annual audit, the auditor reviewed 13 patient electronic health records and found four records were missing and/or contained incomplete documentation of the administration or refusal of the influenza vaccine. This critical issue was not re-evaluated during the limited review because the influenza vaccine is offered annually. Therefore, this critical issue remains unresolved and will be re-evaluated during subsequent audits.

## CONCLUSION

During the March 2018 Annual Audit, Components 6, 8, and 10 failed to achieve an overall passing compliance score, and 19 critical issues were identified. As a result of the limited review audit, one component received a passing score and 11 critical issues were found resolved.

Component 6, *Emergency Services and Community Hospital Discharge*, received an overall component score of 79.4%, which is a slight increase of 0.7 percentage points from the 78.7% compliance score received during the annual audit. Auditors found the nursing staff continue to perform below the minimal compliance threshold, scoring 69.2%, an increase of 5.6 percentage points from the 63.6% compliance score received during the annual audit. The physician case reviews section received a compliance score of 88.9% during the limited review, an increase of 1.4 percentage points from the annual audit score of 87.5%. One critical issue, Question 6.1, remains unresolved. The nursing staff do not consistently review the discharge plans/instructions upon a patient's return from a community hospital visit. If the discharge plan/instructions are not available, nursing staff are to document the reason and steps taken to acquire them.

Component 8, *Medical/Medication Management*, received an overall compliance score of 93.0% during the limited review, an increase of 17.5 percentage points from the 75.5% received during the annual audit. During the limited review, DVMCCF improved the physician case review score by achieving a compliance score of 85.0%, a 35 percentage point increase from the 50.0% compliance score achieved during the annual audit. The nursing case reviews also improved, achieving a compliance score of 95.5%, a 10.9 percentage point increase from the 84.6% compliance score achieved during the annual audit. The two critical issues identified for this component have been resolved. The facility consistently provides the patients their chronic care medication within the specified time frames and administers newly prescribed medication to patients within the specified time frames.

Component 10, *Specialty Services*, received an overall compliance score of 68.5% during the limited review, which is a decrease of 3.7 percentage points from the 72.2% received during the annual audit. Auditors found the facility was unable to resolve the two critical issues and failed to achieve a minimum score of 80% for both the nursing and physician case reviews. Upon a patient's return to the facility from a specialty services appointment, the facility nurses are urged to document when new orders or instructions from the specialty consultant are reviewed, and to notify the PCP of any immediate medication or follow-up appointments recommended by the specialty consultant. In addition, the facility is directed by the physician auditor to fax new RFSs to the Utilization Management Nurse at the hub institution for approval rather than transport the patient to the hub for evaluation.

The remainder of the critical issues previously identified in Components 1, 2, 4, 7, and 11 were also re-evaluated. There were 15 critical issues for these components. As a result of the limited review, 11 were found resolved and one was unable to be rated. The facility is commended for resolving these critical issues. The audit team is very encouraged by their success.

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

# APPENDIX A – QUANTITATIVE REVIEW RESULTS – Critical Issues Only

| *2. Internal Monitoring & Quality Management* | | Audit Type | Yes | No | Compliance | Change |
|---|---|---|---|---|---|---|
| 2.1 | Did the facility hold a Quality Management Committee meeting a minimum of once per month? | A | 3 | 1 | 75.0% | +25.0 |
| | | LR | 4 | 0 | 100.0% | |
| 2.4 | Did the facility submit the required monitoring logs by the scheduled date per Private Prison Compliance and Monitoring Unit program standards? | A | 40 | 22 | 64.5% | -3.2 |
| | | LR | 38 | 24 | 61.3% | |
| 2.5 | Is data documented on the sick call monitoring log accurate? | A | 13 | 5 | 72.2% | +21.9 |
| | | LR | 16 | 1 | 94.1% | |
| 2.6 | Is data documented on the specialty care monitoring log accurate? | A | 14 | 4 | 77.8% | -6.4 |
| | | LR | 10 | 4 | 71.4% | |
| 2.7 | Is data documented on the hospital stay/emergency department monitoring log accurate? | A | 11 | 5 | 68.8% | +6.2 |
| | | LR | 10 | 3 | 75.0% | |
| 2.13 | Are institutional level health care grievances being processed within specified time frames? | A | 8 | 5 | 61.5% | -21.5 |
| | | LR | 6 | 9 | 40.0% | |

**Comments:**

**2.4** Of 62 logs required to be submitted during the audit review period, 38 were received timely. The three weekly logs were submitted late six times, twice during the months of April and May 2018, and once during June and July 2018. The facility submitted the blank monthly logs during April and May 2018. Two monthly logs were submitted late during June 2018.

**2.5** Of the 17 entries evaluated, 1 entry was identified to have an inaccurate date of receipt of sick call request.

**2.6** Of the 14 entries evaluated, 4 were identified to be non-compliant. For the first non-compliant entry, the *Request for Services* (RFS) form for Rheumatology could not be located in the patient's electronic health record per the PCP referral date documented in the log. The date of PCP assessment was also missing for this entry. The second entry was non-compliant due to the wrong CDCR number documented on the log. The third entry had the wrong PCP assessment date documented, and for the fourth non-compliant entry, the PCP referral date documented on the log was different from the date documented on the RFS form, and the date of PCP assessment (following the specialty care appointment) documented was not the same as the date on the PCP's progress note filed in the patient's health record.

**2.7** Three of the 12 entries evaluated were non-compliant. For the first non-compliant entry, a wrong CDCR number was documented on the log, the second entry had the PCP assessment date (following the patient's return to DVMCCF) incorrectly documented, and the third entry was non-compliant due to the dates of patient's return to the facility, and dates of RN and PCP assessments missing on the log.

**2.13** A total of 17 health care grievances were received and processed by DVMCCF during the audit review period. Two of these had been withdrawn by patients within the 45-day time frame and therefore were excluded from review. Of the remaining 15 health care grievances reviewed, nine health care grievances were non-compliant. Two grievances were withdrawn within 45-day time frame; however, a reason for withdrawal was not documented on the CDCR Form 602 HC, *Health Care Grievance,* and the remaining seven health care grievances were not reviewed by the nursing staff within 24 hours of receipt.

| *6. **Emergency Services & Community Hospital Discharge*** | | Audit Type | Yes | No | Compliance | Change |
|---|---|---|---|---|---|---|
| 6.1 | *For patients discharged from a community hospital:* Did the registered nurse review the discharge plan/instructions upon patient's return? | A | 4 | 6 | 40.0% | -20.0 |
| | | LR | 2 | 8 | 20.0% | |
| 6.2 | *For patients discharged from a community hospital:* Did the RN complete a face-to-face assessment prior to the patient being re-housed? | A | 10 | 0 | 100.0% | 0.0 |
| | | LR | 10 | 0 | 100.0% | |
| 6.3 | *For patients discharged from a community hospital:* Was the patient seen by the primary care provider for a follow-up appointment within five calendar days of return? | A | 10 | 0 | 100.0% | 0.0 |
| | | LR | 9 | 0 | 100.0% | |
| 6.4 | *For patients discharged from a community hospital:* Were all prescribed medications administered/ delivered to the patient per policy or as ordered by the primary care provider? | A | 8 | 0 | 100.0% | 0.0 |
| | | LR | 7 | 0 | 100.0% | |
| **Overall Percentage Score and Change:** | | | | **Annual** | **85.0%** | **-5.0** |
| | | | | **Limited Review** | **80.0%** | |

**Comments:**

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

| *7. Initial Health Assessment and Health Care Transfers* | | Audit Type | Yes | No | Compliance | Change |
|---|---|---|---|---|---|---|
| 7.2 | If YES was answered to any of the questions on the Initial Health Screening form (CDCR Form 7277/7277A or similar form), did the registered nurse document an assessment of the patient? | A | 8 | 3 | 72.7% | +27.3 |
| | | LR | 7 | 0 | 100.0% | |
| 7.3 | If the patient required referral to an appropriate provider based on the registered nurse's disposition, was the patient seen within the required time frame? | A | 8 | 4 | 66.7% | +33.3 |
| | | LR | 12 | 0 | 100.0% | |

**Comments:**

None.

| *8. Medical/Medication Management* | | Audit Type | Yes | No | Compliance | Change |
|---|---|---|---|---|---|---|
| 8.1 | Were the patient's chronic care medications received by the patient within the required time frame? | A | 7 | 9 | 43.8% | +56.2 |
| | | LR | 16 | 0 | 100.0% | |
| 8.2 | *For patients prescribed anti-Tuberculosis medication(s):* Did the facility monitor the patient monthly while he/she is on the medication(s)? | A | N/A | N/A | N/A | N/A |
| | | LR | N/A | N/A | N/A | |
| 8.3 | If the patient did not show or refused the nurse administered/direct observation therapy medication(s) for three consecutive days or 50 percent or more doses in a week, was the patient referred to a PCP? | A | N/A | N/A | N/A | N/A |
| | | LR | N/A | N/A | N/A | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 8.4 | *For patients prescribed anti-Tuberculosis medication(s):* Did the facility administer the medication(s) to the patient as prescribed? | A | N/A | N/A | N/A | N/A |
| | | LR | N/A | N/A | N/A | |
| 8.5 | Did the facility monitor the patient monthly while he/she is on the medication(s)? | A | N/A | N/A | N/A | N/A |
| | | LR | N/A | N/A | N/A | |
| 8.6 | Did the prescribing primary care provider document that the patient was provided education on the newly prescribed medication(s)? | A | 12 | 0 | 100.0% | -12.5 |
| | | LR | 14 | 2 | 87.5% | |
| 8.7 | Was the initial dose of the newly prescribed medication administered to the patient as ordered by the provider? | A | 9 | 3 | 75.0% | +25.0 |
| | | LR | 16 | 0 | 100.0% | |
| 8.8 | Did the nursing staff confirm the identity of a patient prior to the delivery or administration of medication(s)? | A | 1 | 0 | 100.0% | 0.0 |
| | | LR | 2 | 0 | 100.0% | |
| 8.9 | Did the same medication nurse who administers the nurse administered/ direct observation therapy medication prepare the medication just prior to administration? | A | 1 | 0 | 100.0% | 0.0 |
| | | LR | 1 | 0 | 100.0% | |
| 8.10 | Did the medication nurse directly observe the patient taking nurse administered/direct observation therapy medication? | A | 1 | 0 | 100.0% | 0.0 |
| | | LR | 1 | 0 | 100.0% | |
| 8.11 | Did the medication nurse document the administration of nurse administered/ direct observation therapy medications on the *Medication Administration Record* once the medication was given to the patient? | A | 1 | 0 | 100.0% | 0.0 |
| | | LR | 1 | 0 | 100.0% | |
| 8.12 | Is nursing staff knowledgeable on the Medication Error Reporting procedure? | A | 1 | 0 | 100.0% | 0.0 |
| | | LR | 4 | 0 | 100.0% | |
| 8.13 | Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food or laboratory specimens? | A | 1 | 0 | 100.0% | 0.0 |
| | | LR | 1 | 0 | 100.0% | |
| 8.14 | Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily? | A | 62 | 0 | 100.0% | -1.7 |
| | | LR | 59 | 1 | 98.3% | |
| 8.15 | Does the facility employ medication security controls over narcotic medications assigned to its clinic areas? (COCF only) | A | N/A | N/A | N/A | N/A |
| | | LR | N/A | N/A | N/A | |
| 8.16 | Are the narcotics inventoried at every shift change by two licensed health care staff? (COCF only) | A | N/A | N/A | N/A | N/A |
| | | LR | N/A | N/A | N/A | |
| 8.17 | Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers or nitroglycerine tablets? (COCF Only) | A | N/A | N/A | N/A | N/A |
| | | LR | N/A | N/A | N/A | |
| **Overall Percentage Score and Change:** | | | | **Annual** | **91.9%** | **+ 6.7** |
| | | | | **Limited Review** | **98.6%** | |

**Comments:**

**8.2 and 8.3** There were no patients identified who refused their keep on person (KOP) or NA/DOT medications during the audit review period.

**8.4 and 8.5** There were no patients on anti-Tuberculosis medication(s) housed in DVMCCF during the audit review period.

**8.6** The NCPR auditor reviewed 14 electronic health records of patients who were prescribed new medications and found two records did not have documentation to show the provider educated the patients on the newly prescribed medications.

**8.14** The NCPR auditor reviewed the medication room's refrigerator log and found the temperature was recorded too high on one of the 62 times the refrigerator was checked by health care staff during a one month period.

**8.15 through 8.17** These questions do not apply to California in-state modified community correctional facilities.

| *10. Specialty Services* | | Audit Type | Yes | No | Compliance | Change |
|---|---|---|---|---|---|---|
| 10.1 | Was the patient seen by the specialist for a specialty services referral within the specified time frame? | A | 16 | 0 | 100.0% | 0.0 |
| | | LR | 4 | 0 | 100.0% | |
| 10.2 | Upon the patient's return from the specialty service appointment, did the registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit? | A | 15 | 1 | 93.8% | +6.2 |
| | | LR | 4 | 0 | 100.0% | |
| 10.3 | Upon the patient's return from the specialty services appointment, did the registered nurse notify the primary care provider of any immediate medication or follow-up requirements provided by the specialty consultant? | A | 0 | 7 | 0.0% | 0.0 |
| | | LR | 0 | 4 | 0.0% | |
| 10.4 | Did the primary care provider review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patient within the required time frame? | A | 15 | 1 | 93.8% | +6.2 |
| | | LR | 4 | 0 | 100.0% | |
| **Overall Percentage Score and Change:** | | | | **Annual** | **71.9%** | **+ 3.1** |
| | | | | **Limited Review** | **75.0%** | |

**Comments:**

**10.3** The NCPR auditor reviewed four electronic health records of patients who returned from specialty care appointments and found none of the records had documentation to show the RN notified the facility provider of any immediate medication or follow-up appointments recommended by the specialty consultant.

| *11. Preventive Services* | | Audit Type | Yes | No | Compliance | Change |
|---|---|---|---|---|---|---|
| 11.2 | *For all patients*:<br>Were patients offered an influenza vaccination for the most recent influenza season? | A | 9 | 4 | 69.2% | N/A |
| | | LR | N/A | N/A | N/A | |

**Comments:**

**11.2** This question is evaluated only once every year. Therefore, this will be evaluated for compliance during the next scheduled annual audit.

## APPENDIX B – PATIENT INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the patient population, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. This is accomplished via interview of all the Americans with Disability Act (ADA) patients housed at the facility, the Inmate Advisory Council (IAC) executive body, and a random sample of patients housed in general population (GP). The results of the interviews conducted at DVMCCF are summarized in the table below.

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

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

**Comments**:

The auditors interviewed 14 patients during the onsite portion of the limited review (four IAC members and an additional 10 patients, 3 of whom were ADA/DPP).

Similar to the annual audit, the IAC members reported they felt the care rendered to the patient population was satisfactory and the quality of the nursing staff excellent. All four members of the IAC stated that the current provider lacks empathy, appears unconcerned and eager to conclude the encounters with patients.

The IAC discussed four separate patients where they felt medical care was inadequate. After the conclusion of the interviews, the physician auditor reviewed the four electronic health records of the patients identified as having received inadequate health care and found no deviation from the standard of care noted.

The three ADA patients at DVMCCF were interviewed by the PPCMU auditors while onsite. One patient required a hearing impaired vest, another patient had a cane and a knee brace and the third patient said he has a temporary boot but is waiting for approval of an orthopedic shoe. The three ADA patients clearly explained the process to request reasonable accommodations and where to acquire a reasonable accommodation request form. All three ADA patients were familiar with the health care grievance and appeals process for disability related issues. One patient reported having to use the health care grievance process and alleged it took 4 months to complete. Two of the ADA patients were unaware of the ADA coordinator's name. One ADA patient expressed concern that he believes he may have a learning disability and asked the PPCMU auditors who he can get in contact with to help diagnose it. At the conclusion of the ADA interviews, the PPCMU auditors spoke with the HSA to discuss the patient who believes he might have a learning disability and the two patients who were not aware of who the ADA coordinator is. The facility's HSA reached out to the patients while the PPCMU auditors were on site to attempt to resolve these issues. The patients are now made aware of who the ADA coordinator is and the patient who thinks he has a learning disability was scheduled to see the HSA the next day.

The auditors requested to interview seven patients randomly chosen from the facility's general population roster. All seven patients were able to describe the process for requesting health care services. All the patients clearly explained the process for requesting health care services, where to find the forms and how to submit the forms. All the patients interviewed spoke very highly about the facility's nursing staff. All the patients said they would ask their fellow patients for help filling out a request for health care services if they were not able to fill one out. The PPCMU auditors explained they should ask their health care team to complete the form on their behalf if they are not able to complete it and not their fellow patients. All the patients reported they were aware of the process to file a health care grievance but no one was aware of the process to appeal a grievance decision. All the patients interviewed said they would reach out to their fellow patients if they needed assistance with filling out a grievance form. The PPCMU auditors explained the correct process for appealing a grievance and requesting assistance with completing a form.

Overall, the patients interviewed during the onsite audit expressed their satisfaction with the health care services provided to them.

# APPENDIX C – BACKGROUND AND AUDIT METHODOLOGY

## 1. BACKGROUND AND PROCESS CHANGES

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

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

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

## 2. OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

## Quantitative Review

The *quantitative* review uses a standardized audit instrument, which measures compliance against established standards at each facility. The audit instrument calculates an overall percentage score for each of the chapters in the *Administrative* and *Medical Component* sections as well as individual ratings for each component of the audit instrument.

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 12 medical and three administrative components of health care to measure. The *Medical* components cover clinical categories directly relating to the health care provided to patients, whereas the *Administrative* components address the organizational functions that support a health care delivery system.

The 12 medical program components are: *Access to Care, Diagnostic Services, Emergency Services and Community Hospital Discharge, Initial Health Assessment/Health Care Transfer, Medical/Medication Management, Observation Cells, Specialty Services, Preventive Services, Emergency Medical Response/Drills and Equipment, Clinical Environment, Quality of Nursing Performance* and *Quality of Provider Performance.* The three administrative components are: *Administrative Operations, Internal Monitoring and Quality Management and Licensing/Certifications, Training and Staffing.*

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

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

The compliance score for each question is expressed as a percentage rounded to the nearest tenth. For example, a question scored 13 'Yes', 3 'N/A', and 4 'No".

Compliance Score = 13 'Yes' / 17 (13 'Yes' + 4 'No') = .764 x 100 = 76.47 rounded up to 76.5%.

The component scores are calculated by taking the average of all the compliance scores for all applicable questions within that component. The outcome is expressed as a percentage rounded to the nearest tenth. The qualitative rating for each component is described as *Proficient*, *Adequate*, or *Inadequate* according to whether standards were met more than 90%, more than 80% or less than 80%. See Table below for the breakdown of percentages and its respective quality ratings.

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

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

## Qualitative Review

The *qualitative* portion of the audit consists of case reviews conducted by clinical auditors. The clinical auditors include physicians and registered nurses. The clinicians complete clinical case reviews in order to evaluate the quality and timeliness of care provided by the clinicians at the facilities. Individual patient cases are selected and followed utilizing an individual case review similar to well established methods utilized by the Joint Commission on Accreditation of Healthcare. Typically, individuals selected for the case review are those who have received multiple or complex services or have been identified with poorly controlled chronic conditions.

The cases are analyzed for documentation related to access to care, specialty care services, diagnostic services, medication management and urgent or emergent encounters. Once the required documentation is located in the record, the clinicians review the documentation to ensure that the abovementioned services were provided to the patients in accordance with the standards and scope of practice and the IMSP&P guidelines and to ensure complete and current documentation.

The clinical case reviews are comprised of the following components:

1. *Nurse Case Review*

   The NCPR auditors perform two types of case reviews:

   a. Detailed reviews – A retrospective review of ten selected patient health records is completed in order to evaluate the quality and timeliness of care provided by the facility's nursing staff during the audit review period.
   b. Focused reviews – Five cases are selected from the audit review period of which three cases consist of patients who were transferred into the facility and two cases consist of patients transferred out of the facility with pending medical, mental health, or dental appointments. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations, continuity of care, and completeness of the transfer forms.

2. *Physician Case Review*

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

## Overall Component Rating

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

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

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

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

## Overall Audit Rating

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

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

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

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

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

## Scoring for Non-Applicable Questions and Double-Failures:

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

## Resolution of Critical Issues

Although the facility will not be required to submit a corrective action plan to the Private Prison Compliance and Monitoring Unit for review, the facility will be required to address and resolve all standards rated by the audit that have fallen below the 80.0% compliance or as otherwise specified in the methodology. The facility will also be expected to address and resolve any critical deficiencies identified during the clinical case reviews and any deficiencies identified via the observations/inspections conducted during the onsite audit.