EXHIBIT 2

DUVALL SETTLEMENT AGREEMENT REPORT

April 10, 2023

MICHAEL PUISIS, DO

Contents

OVERVIEW 4
EXECUTIVE SUMMARY 4
17: INTAKE AND INITIATION OF MEDICATION 7
Provision 17 Compliance: Partial Compliance 7
Settlement Agreement Statement: 17.a. 7
Settlement Agreement Statement: 17.b. 13
Settlement Agreement Statement: 17.c. 14
Settlement Agreement Statement: 17.d. 14
Settlement Agreement Statement: 17.e. 16
18: MEDICAL PLAN OF CARE 18
Provision 18 Compliance: Partial Compliance 18
Settlement Agreement Statement: 18.a. 18
Settlement Agreement Statement: 18.b. 20
Settlement Agreement Statement: 18.c. 21
Settlement Agreement Statement: 18.d. 23
Settlement Agreement Statement: 18.e. 24
Settlement Agreement Statement: 18.f. 25
MEDICATION MANAGEMENT AND TESTING 27
Provision 19 Compliance: Noncompliance 27
Settlement Agreement Statement: 19.a. 27
Settlement Agreement Statement: 19.b. 30
Settlement Agreement Statement: 19.c. 32
Settlement Agreement Statement: 19.d. 34
Settlement Agreement Statement: 19.e. 35
Settlement Agreement Statement: 19.f. 36
Settlement Agreement Statement: 19.g. 38
INTERACTION BETWEEN MEDICAL AND CUSTODY 40
Provision 20 Compliance: Partial Compliance 40
Settlement Agreement Statement: 20.a. 40

Settlement Agreement Statement: 20.b. 42
Settlement Agreement Statement: 20.c. 45
Settlement Agreement Statement: 20.d. 47
Settlement Agreement Statement: 20.e. 48
Settlement Agreement Statement: 20.f. 48
Settlement Agreement Statement: 20.g. 49
ACCOMMODATION FOR PLAINTIFFS WITH DISABILITIES 49
Provision 21 Compliance: Partial Compliance 49
Settlement Agreement Statement: 21.a. 49
Settlement Agreement Statement: 21.b. 56
Settlement Agreement Statement: 21.c. 59
Settlement Agreement Statement: 21.d. 61
SPECIALTY CARE/CONSULTATION 61
Specialty Care Compliance: Noncompliance 61
Settlement Agreement Statement: 22.a. 61
Settlement Agreement Statement: 22.b. 63
Settlement Agreement Statement: 22.c. 67
Settlement Agreement Statement: 22.d. 68
Settlement Agreement Statement: 22.e. 72
SICK CALL 72
Provision 23 Compliance: Substantial Compliance 72
Settlement Agreement Statement: 23.a. 72
Settlement Agreement Statement: 23.b. 72
Settlement Agreement Statement: 23.c. 73
Settlement Agreement Statement: 23.d. 73
MEDICAL RECORDS 74
Provision 24 Compliance: Partial Compliance 74
Settlement Agreement Statement: 24.a. 74

OVERVIEW

Consistent with provision 38.d, when the Commissioner claims to have attained substantial compliance with any provision of the Settlement Agreement, the Monitor is to issue a report within two months of the claim of substantial compliance. The Commissioner asserts compliance with provisions 17c, 20b-g, 21a-d, 23a-d. The report will include a brief executive summary. Each provision of the report will be stated verbatim in italics as a Settlement Agreement Statement. Following that I will give a compliance rating for that item. The Settlement Agreement defines compliance as meaning:

> "(a) full compliance with the components of the relevant substantive provision of this Settlement Agreement; or (b) sufficient compliance with the components of the relevant substantive provision of this Settlement Agreement such as to remove significant threat of constitutional injury to the plaintiff class posed by any lack of compliance with the components of that substantive provision.

The Settlement Agreement requires that judging compliance be done for each of the eight substantive provisions which are delineated in the single numbered paragraphs of Section III of the Settlement Agreement. That will be done. The Monitor provides a compliance rating for subsections of each provision to give Defendants a more focused gauge on what they need to work on to attain compliance.

EXECUTIVE SUMMARY

The Commissioner has asserted compliance with two provisions 21 and 23. The Monitor has found only provision 23 compliant. There are eight substantive provisions. Provision 23 is compliant; provisions 17, 18, 20, 21, and 24 are partially compliant; and provisions 19 and 22 are noncompliant.

There are 37 subsections of the eight provisions. DPSCS has asserted compliance with 14 medical subsections.[1] The Monitor has found compliance with eight subsections.

The current status of the 37 subsections is:

1. Eight provisions are substantially compliant. Twenty two provisions are partially compliant. Seven provisions are still non-compliant. Two provisions have moved from noncompliant to partially compliant.

A summary of compliance ratings is found at the end of this report. The visit took place 3/15/23 to 3/17/23.

[1] 20b-g, 21a-d, 23a-d

DPSCS has made improvements and has initiated work in multiple areas including the following.

- Dr. Oscar Jerkins has been appointed the Medical Director of DPSCS.
- Akisha Price was named the Director of Health Services and Duvall Compliance. Ms. Price joins Holly Turner, the Chief of Compliance and Integrity. These individuals work under Commissioner Randolph.
- DPSCS reported that Wi-Fi was installed at BCBIC and MTC.
- ADA bathrooms were renovated at MTC
- A mobile urgent care team was created.
- Beds on the infirmary were upgraded.
- ADA rounds were initiated on the infirmary.
- DPSCS continues to implement centralized scheduling.
- Administrative staff have been assigned to fixing the nurse task process.
- Two root cause analyses were completed; intake ADA and medication administration root cause analyses. Corrective actions were developed but are not completed.
- DPSCS has partially implemented an upgrade to the electronic record.

A major focus of attention this report period was the ongoing upgrade of the electronic record. About six months ago, Information Technology and Communications Divisions (ITCD) ended negotiations with Fusion, a medical record vendor, and cancelled the project. At the time, DPSCS was temporarily implementing an upgrade to the existing medical record, NextGen, which was intended to cover the period until the new record was implemented. When the contract with Fusion was cancelled, the upgrade with NextGen became not just an upgrade but a new implementation project. DPSCS had not prepared for this and the implementation became an incremental implementation that has not been smooth. The implementation of the record started almost a year ago and is not over.

Implementation of the electronic record is not a trivial task and ITCD has not had experience in such an implementation previously. New functionality was added but training was not sufficient or effective and many process issues appeared because staff was incorrectly using the software and because there were multiple options to perform certain functions that resulted in unexpected results. These unexpected results surfaced over time. Instead of eliminating bugs to the software in a test environment and making sure the product worked as intended before actual implementation, DPSCS is identifying errors after the implementation. The result was a medical record that resulted in errors, multiple bugs, and a multiplicity of ways to present data that was confusing to staff and myself when I performed record reviews. The final product has not satisfied the customer who are the physicians and nurses who have to use the product. Error correction is ongoing in real time. Because the implementation was fragmented and incremental, the IMMS does not yet utilize the new NextGen IMMS form. The electronic medication administration record is not yet implemented with no visibility to an end date. Software bugs, interface problems, and lack of functionality must be corrected.

Added to this, ITCD stated that they are having difficulty accessing or using data in the electronic record to perform queries that would provide the data to verify compliance with the Settlement Agreement and for other purposes. The complex data structure of the

electronic record was not appreciated and getting data out has been more complex than anticipated. The expectation of DPSCS was that supervisory clinical staff could use Crystal Reports[2] to produce the reports they needed to verify the Settlement Agreement, but this has not been working well.

It does not appear that there are sufficient devices for staff to use despite purchase of some tablet computers. A device survey based on functional work assignment analysis has not been performed.

The functional requirements for an electronic record may have been developed but testing in a test environment was not done effectively in advance of implementation. Errors picked up in medical record reviews indicate that there may still be problems with interfaces between the laboratory, pharmacy, the electronic record and the Offender Case Management System (OCMS).

Because of these difficulties, DPSCS should hire a consulting firm to complete implementation the record and to assess whether the data structure of the existing record is accessible for data queries and how accurate data may be obtained. If the existing record is amenable to data queries needed for the Settlement Agreement the consultant should develop a program perform these queries.

There have been improvements in the physical plant on the infirmary.

I have recommended in a few areas that DPSCS needs to revise its policy to match current practice which is changing with the new electronic record upgrade. Dr. Jerkins should be alerted to those recommendations to revise policy. Though the policies are used for the prison system, they need to be appropriate for BCBIC which is a jail.

I recommended separation of accept/reject screening from IMMS screening. Accept/reject screening can be performed in the current COVID screening tent just outside the sally port. I gave comments on the new IMMS form and advise the accept/reject form be separate from the IMMS form. Multiple comments were provided on current NextGen screens.

I gave recommendations to modify the Combined Chart Summary. This summary should be embedded in the note the provider is using so that screens don't have to change to open the links in the Summary.

ITCD has stated that there is no server capacity issue, so DPSCS should immediately begin scanning medication administration records (MARs) to the chart. I suggest each entire month of medication administration records be scanned to the last day of the month.

[2] Crystal reports is a windows based report writer that allows the user to create reports from a data source. In this case the data source is the data base of the electronic record.

Because the electronic record is installed DPSCS should immediately begin evaluating how to perform data queries to provide data to DPSCS in various areas. An initial recommendation was to perform a data query to obtain the list of all persons with a low bunk based on orders from NextGen. This should be compared to the list of all low bunks from the OCMS software. A data comparison will yield an answer to part of 20b and 21a requirement. I still firmly recommend hiring the data team with a project manager for the electronic record for getting data out of the record for the purpose of verification.

DPSCS asserted compliance with provision 21. But timely delivery of accommodations does not consistently occur particularly in the sally port. DPSCS needs to modify intake procedures and ensure that persons with disability are identified and receive their accommodation as soon as possible. Examinations of those with disabilities could be improved for mobility disorders and cognitive disorders.

In record reviews, I noted two patients who requested vaccination for COVID. One placed a health request stating he requested to be vaccinated five times. Another inmate requested vaccination three times. I couldn't find evidence that these patients were vaccinated. There were also numerous problems on problems lists that stated vaccine for viral disease COVID but there was no explanation in the record what these meant or whether the patient was offered vaccination. On limited record reviews I did not notice a standardized effort to vaccinate. Given that the current public strategy to address COVID is vaccination, DPSCS should ensure that vaccination is offered to all inmates in intake.

Twenty one record reviews were completed and are provided as an attachment. Patient identifiers will be sent in a separate email following the report.

I want to thank all the staff who gave freely of their time to inform me of their work. I appreciate the work they do.

17: INTAKE AND INITIATION OF MEDICATION

Provision 17 Compliance: Partial Compliance

Settlement Agreement Statement: 17.a. *The Commissioner shall promulgate and implement policy and procedure to provide adequate medical and mental health intake screening to all plaintiffs accepted for admission at BCBIC. Such policy shall provide that initial medical and mental health screening, including rejection or acceptance for admission of the plaintiff, is performed by a RN within four hours of arrival at BCBIC, provided the plaintiff is present for all four of those hours. If the plaintiff is rejected for admission and later returns to BCBIC, a new four-hour period within which the initial medical and mental health screening must be performed shall commence.*

Compliance Rating: Partial Compliance

Findings:

This provision requires verification of several items including:

1. Verification that IMMSs are completed within 4 hours of booking.
2. That an RN perform all IMMS evaluations.
3. That persons rejected have an IMMS within 4 hours of return to the facility. This would require knowing all those who are rejected.
4. That the IMMS be of adequate quality.

The Department of Public Safety and Correctional Services (DPSCS) does not claim compliance for this item.

YesCare reported data based on a 366 (5%) individual sample of records out of 7596 bookings looking at the scan time to time of IMMS. 97% of IMMS evaluations were completed within two hours. RNs consistently performed the IMMS. DPSCS still finds that transfer of the IMMS to the electronic record does not consistently occur and affects scoring. IMMS results transfer to the electronic record on average 87% of the time.

Over the six months for this report, 113 individuals were rejected on arrival and sent to a hospital. This is about 19 individuals a month. For persons who were rejected and had intake screening at a later time, their IMMS migrated to the EPHR within 4 hours (93% of the time) a significant difference than for those initially booked. The actual time to completion of the IMMS was not noted though I presumed that the migration of the IMMS to the EPHR was a proxy for completion of the IMMS. This is not explained. In review of records, one individual[3] went to a hospital emergency room on 1/17/23 but only an after-summary was obtained and it was not clear when he returned from the hospital because there was no documentation in the electronic record. An IMMS was not performed until 12:09 pm on 1/18/23. The electronic record does not document rejects but should do so.

The quality of nurse screening has not changed since the last report. Each week ten records of a single nurse assigned to intake IMMS screening are reviewed by an audit team registered nurse. The items reviewed include:

1. The intake screening form if completed with no blanks.
2. Vital signs including capillary blood glucose for persons with diabetes, peak flow for persons with diabetes.
3. Point of care testing is documented in the comments section to include rapid HIV testing and HCG testing (pregnancy test) for females.
4. A baseline CIWA or COWS are documented on the IMMS for all individuals who report drug or alcohol use.
5. The individual was triaged and referred appropriately based on nursing assessment and IMMS responses.
6. Checked boxes on the IMMS correspond with nurses remarks in the comments section.

[3] Patient 11

7. For reject returns, did the nurse address the reject reasons in the IMMS upon return and refer appropriately.
8. Did disposition in IMMS correspond to the disposition on the SSR log.
9. Did provider's assessment correspond with nurse findings as documented in IMMS.
10. Did the nurses' medication history match the provider's medication documentation.

Items 1-8 above all scored at least 90% or above on average. Items 9 and 10 scored 40 and 69% respectively. DPSCS did not explain why items 9 and 10 scored so low.

The YesCare report identified a finding that community prescribed medications were often documented on the medication verification form but not on the IMMS. I found a different version of the same problem. Nurses received a patient from a hospital with a list of medications they received at the hospital but failed to acknowledge that the patient received the medication at the hospital or even that the patient was just discharged from the hospital. This verifies an extremely rushed intake process that does not even consider recent hospitalization as important enough to discuss in the IMMS.

Multiple quality and process issues are not picked up in this audit which is mainly a compliance type audit. A generic example of this is the "no" answer in the IMMS that is inaccurate. A specific example is an IMMS on which a nurse documented "no" to the question whether the patient[4] had a medical problem. The nurse then answered "yes" to the question whether the patient used medication and documented propranolol in the comment section. But the sally port paperwork documented that the patient was on atorvastatin and propranolol. I would grade this as noncompliant for 17a on the basis of quality because the nurse failed to check the "yes" box that the patient had a medical problem because he obviously had a problem and because the patient was known to be on atorvastatin and propranolol but the nurse only documented propranolol. There were a number of examples of nurses checking the "no" box when it is obviously inaccurate. When this was mentioned to some staff, I was told that under certain circumstances nurses are unable to obtain a "yes" answer and have to click "no" to continue the IMMS. This was confirmed by several staff and DPSCS should verify this because if this is accurate it must be corrected.

Some patients with disabilities need an accommodation promptly upon arrival at the jail. Others need medication ordered as soon as or shortly after the nurse performing the IMMS identifies the medication need. This is true for medications such as insulin, antirejection medication, clopidogrel for stents, etc. The IMMS form does not have space to document whether the nurse called for a medication order nor whether the nurse provided or called for an order to provide prompt medication or ADA needs. The nurse performing the IMMS needs to do this and the IMMS form needs to provider space to document whether nurses obtain a prompt order.

DPSCS told me that there is procedure to place a colored wrist band on persons who need early attention. But this process is not effective. An example is a patient[5] who was sent to an emergency room for high blood sugar. He was given insulin at the hospital at 7:50 am on 12/28/22. The patient returned to the jail and had his IMMS at 1:30 pm on 12/28/22 when the blood sugar was 213. No insulin was documented as ordered at that time. The patient did not see a provider until

[4] Patient 2
[5] Patient 6

8:49 pm. At 8:49 pm (about 14 hours after last insulin at the hospital and 7.5 hours after the IMMS) when the provider saw the patient, the blood sugar was 482 which is very high. Insulin was ordered then but was not documented as given until 11:27 pm (about 18 hours after the last insulin) and the blood sugar was 440. Only 6 units of regular insulin was given. The ordered Lantus insulin was not given until the following day at 7:10 pm. Though the provider ordered 5 units of regular insulin with meals for blood sugars between 200 to 350, the blood sugar was not documented as checked at breakfast or lunch on the 11/29/22. There was no medication administration record in the electronic record. DPSCS should review their procedure to ensure that for persons on insulin or other critical medications, that prompt orders and administration of medications can be provided. Patients on insulin or other critical medications (insulin, rejection medication, clopidogrel for stents, etc.) should see a provider immediately after identification of one of these critical medications by a nurse. This does not now occur and patients appear to get lost in the sally port which is a dangerous housing unit.

With respect to disability accommodation, a patient[6] who had nerve injury to his leg used a cane but though the nurse referred to a provider urgently an accommodation was not provided. Nurses are not permitted to provide durable medical equipment supplies without an order. If nurses are not permitted to provide temporary durable equipment until a provider can evaluate the patient, then the patient needs to be seen immediately by a provider after the nurse sees the patient. This patient did not see a provider for 16 hours.

Twenty medical records were reviewed for this report period. There were 33 quality issues identified with respect to the IMMS. These can be evaluated in the record review appendix.

One problem identified on these reviews is the problem of rebooking. A patient[7] had an IMMS on 9/14/22 who was just discharge from the hospital after a gunshot wound resulted in a fracture of his leg. The patient also had asthma, opioid use, and alcohol abuse. On 10/12/22 the patient who had not been released from jail was "rebooked and another IMMS was completed. All questions on the IMMS were entered "no" which was inaccurate. This inaccurate IMMS is unnecessary and DPSCS must ensure that rebooking does not result in a second intake screening particularly since the IMMS that is entered for rebooking is inaccurate **(17a, 24).** Why is an IMMS necessary for rebooking? The patient is an active patient who already had an IMMS. What is unclear is whether the IMMS is counted statistically in audits as being timely performed.

On tour, I learned that the accept/reject screening is the IMMS screening. This increases pressure on nurses to quickly complete the IMMS because police officer have to wait for the jail to accept the patient. I have added a recommendation to separate the IMMS from the accept/reject screening. These two screening activities should utilize different forms. Also, I recommend that the accept/reject screening take place in the old COVID screening tent outside the sallyport. This screening would consist of vital signs (including point-of-care testing when indicated) and a quick look triage screen to assess whether anything is occurring with the patient that requires immediate hospital evaluation. If this is done, policy and procedure should be adjusted. The IMMS should

[6] Patient 14
[7] Patient 17

be a separate form with unique and separate vital signs. This should permit the actual IMMS to be performed under less pressure which should improve quality.

DPSCS provided screenshots of a new IMMS electronic form. Preliminarily, I have the following comments.

1. The Accept/Reject screening template should be *completely separate* from the IMMS screening template. Each template should contain its own vital signs. The intermixing of the Accept/Reject with the IMMS has resulted in innumerable problems.
2. Vital screens for Accept/Reject and IMMS should utilize automated vital sign equipment that can synchronize to the electronic record.
3. Anyone suspected of being intoxicated with alcohol should have a capillary blood glucose test included in the vital signs.
4. TB screening does not include TB testing. I recommend QuantiFERON blood testing but Mantoux skin testing is acceptable. If Mantoux skin testing is chosen, it should be applied during the IMMS.
5. Reported Problems and History form
    a. The title of one page is "offender" reported problems and history. This population consists of detainees and they are not convicted and I would eliminate this term.
    b. The "Offender" Reported Problems and History page needs to include a question, "Do you smoke cigarettes or have you smoked cigarettes? If yes, how many packs per day and for how many years have you been smoking?" This should result in a pack/year calculation.
    c. The IMMS should ask patients about homelessness. A suggestion is two questions used as a screening in emergency rooms[8] to include:
        i. Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household? "yes" or "no"
        ii. How likely do you think it would be that you would have to use a homeless shelter in the next 6 months? Answers: very likely, somewhat likely, somewhat unlikely, very unlikely. [9]
    d. Add a question under the hospitalization question, "Do you have a physician in the community? If you receive care from a physician, where do you receive care".
    e. The screening question about type 1 or 2 diabetes is not as important as whether they use insulin. If the patient uses insulin, the nurse should ask about the patient's usual insulin usage and when the last time they used insulin. The nurse should call a provider, provide the information regarding insulin usage, and ask for an insulin order.
6. On the Physical Limitations template, would add the question, "Do you care for yourself at home or do you need someone to help you with any activity?"
7. Above the Medical and Mental Health Disposition form, would include a nurse assessment/observation form. Currently, nurses completing the IMMS only complete a

[8] Performance of a 2 Single-Item Screening Questions to Identify Future Homelessness Among Emergency Department Patients found at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2795146

[9] These questions correlate with future homelessness and will assist in parole planning especially for those with mental illness.

questionnaire and do not perform a nursing assessment to identify needs of the patient. Nurses should perform a brief nurse assessment and observation of the patient to identify any physical abnormality to inform a provider accordingly regarding the needs of the patient.

8. The Medical and Mental Health Disposition need to address those with a disability who need an assistive device, disability accommodation, or who have an urgent medication need (on oxygen, on insulin, using an anti-rejection medication, Plavix, anticoagulant, etc.). Because so many people are labeled "urgent", the individuals mentioned here should be seen by a provider immediately after the nurse evaluates the patient or the nurse should call a provider for orders so that their care is not delayed.

In summary, quality of IMMS evaluation is not yet adequate. Improvement in quality of IMMS screening must occur. Quality audits are not yet identifying quality problems and focus on compliance issues. This provision is, therefore, still partially compliant. The accept/reject screening should be separated from the IMMS. Certain medications and accommodations for disabilities need to be initiated by the nurse performing the IMMS promptly. If this cannot be done, then providers need to evaluate these individuals immediately after the nurse screening. Any rebooking in the medical record that is inaccurate is scored as inaccurate. If rebooking screenings are clinically unnecessary, they should be discontinued. DPSCS ITDC must evaluate the staff complaint that under some circumstances, it is not possible for nurses to enter a "yes" response on the IMMS. This creates errors unnecessarily and makes it difficult to attain compliance. That this has been ongoing for over a year causes concern with respect to ability to correct software errors.

Recommendations:

1. Develop a better method to assess quality of intake evaluations as part of your validation of this provision item.
2. Perform a root cause analysis of the intake process to include interviews with intake nurses to establish whether time-pressures, privacy issues, or space conditions contribute to the poor quality of care of nursing intake evaluations. Take corrective actions on these items. Identified problems need to result in corrective actions to result in compliance with the Settlement Agreement.
3. Develop a standardized intake process.
4. Develop corrective actions based on the root cause analysis and problems identified in Dr. McIlree's Alcohol Substance Abuse history document and in Dr. Abebe's audits.
5. Utilize intake nurse quality reviews to identify and correct problems.
6. Modify policy to correspond to expected current practice.
7. Modify chart selection of IMMS audits for nurse quality to include higher acuity patients.
8. Separate accept/reject screening from the IMMS. The accept/reject screening can be performed in the recently used COVID tent. This screening would consist of vital signs and a quick look triage (with applicable point-of-care testing) to determine if the patient has any serious medical condition that requires immediate hospital evaluation. The IMMS screening would thereby include only person accepted into the jail.

9. DPSCS should expand their root-cause analysis of intake to examine the finding in the YesCare report, "The audit found that community-prescribed medications were often documented on the medication verification form but not on the IMMS".
10. Revise policy and procedure so that nurses who identify an accommodation or medication need (on insulin, anti-rejection drug, etc. or need a cane, crutch, etc.) either are able to contact a provider immediately for a phone order or have a provider immediately see the patient after the nurse evaluation.
11. Immediately discontinue the practice of repeating IMMS screening when a patient is booked on another charge. If this cannot be done, then the nurse must perform the IMMS fully and accurately which I consider wasteful and confusing.
12. ITCD must immediately evaluate and fix the software bug that does not permit nursing staff to enter a "yes" response on the IMMS.

Settlement Agreement Statement: 17.b. *The Commissioner shall ensure that any plaintiff who reports during intake screening that he or she is currently prescribed medication for a medical condition, or who presents with an urgent medical need, shall receive a physical assessment by a Clinician within 24 hours of the intake screening, or sooner if clinically indicated*

Compliance Rating: Partial Compliance

Findings:

DPSCS did not assert compliance with this item. 17b requires verification of two things:

1. Evaluation by a clinician within 24 hours of anyone on a medication, with a medical condition, or with an urgent medical need.
2. Evaluation by a clinician is of sufficient quality.

YesCare audits compliance with the timeline of performing the clinician assessment. Anyone who answers "yes" to any question on the IMMS is a subject of the audit[10]. Any "yes" response is deemed an urgent evaluation. Sixty persons a month are audited and YesCare reports that 97% of persons audited receive a provider assessment within 24 hours. This appears to be credible data based on record reviews.

The YesCare report stated that peer reviews are done to assess provider quality but no summation or other information was provided of these reviews. A review of quality must be done and needs to be provided in the YesCare report.

[10] Because nurses, on occasion, answer "no" to questions that obviously should be answered "yes", the radio button answers do not consistently reflect an accurate population. For example, there were several persons with "no" answers to the question do you have a medical condition, who clearly had a medical problem by virtue of just having been diagnosed with one from the hospital. That said, in these cases, though nurses inaccurately completed the IMMS, they did refer the patient urgently to a provider. Why this occurs is unclear.

DPSCS policy requires that the intake examination[11] "shall identify physical and mental disabilities that require specific treatment accommodations in order for the inmate to successfully navigate the routine demands of correctional environment". Record reviews demonstrate that this is inconsistently done and there are examples of patients who leave intake without appropriate identification or orders for an accommodation. This policy documents that inmates who are identified with disabilities are to have the disability documented in the medical record on the DPSCS Disabilities Assessment Form. I have not seen this form in current record reviews. DPSCS should revise policy given the changes in practice.

The YesCare report documents that the addition of the IMMS to NextGen software will enable use of a dashboard to track intake tasking. This will be useful but there is no firm date on the implementation of this.

In record reviews 36 deficiencies were identified for this provision. Record reviews are attached to this report.

Recommendations:

1. Include record reviews of provider quality of intake assessments and demonstrate how these verify compliance.
2. Revise and update DPSCS policy on inmates with special needs to include the current method for documentation of identification of special needs and ordering the accommodation in intake .

Settlement Agreement Statement: 17.c. *The Commissioner shall ensure that any plaintiff who is identified during intake screening as currently prescribed psychotropic medication (unless he or she receives a bridge order as provided in paragraph 25.b.) or as having an urgent mental health need, including a suicide risk, shall receive a mental health evaluation by a Mental Health Practitioner within 24 hours of the intake screening, or sooner if clinically indicated.*

Compliance Rating: This is a mental health issue not evaluated by the Medical Monitor.

Findings: None

Recommendations: None

Settlement Agreement Statement: 17.d. *To address the needs of plaintiffs who, prior to being taken into custody, were prescribed medication that, if interrupted, would pose a risk of adversely affecting health, the Commissioner shall promulgate and implement policy and procedure to ensure that such plaintiffs receive such medications within 24 hours of the intake screening or subsequent encounter at which the plaintiff first reports such medications to a Medical Professional or Mental Health Professional, or sooner if clinically indicated, unless: (i) a Clinician determines that such continuation is not medically appropriate, including without*

[11] DPSCS Medical Evaluations Manual, Chapter 6, Inmates with Special Needs

limitation a determination that continuation is not medically appropriate pending verification of the reported prescription, provided that appropriate verification efforts shall be promptly undertaken; or (ii) despite reasonable efforts consistent with the gravity of the need for the medication, DPDS is unable to timely obtain the medication. The Commissioner shall promulgate and implement policy and procedure requiring reasonable efforts, consistent with the gravity of the need for the medication, to ensure that such plaintiffs are timely provided with the medication or a pharmaceutical equivalent.

Compliance Rating: Partial Compliance

Findings:

DPSCS does not assert compliance on this item. The DPSCS policy[12] is clear.

> Regardless of the outcome of verification attempts, the medical mid-level/provider will be responsible for identifying and maintaining the arrestee on the pre-incarceration treatment regimens as reported by an arrestee or a pharmacologically equivalent substitute for medical and mental health conditions whenever possible, i.e., the clinician can identify the need for those treatment regimens.

This is consistent with requirements of the Settlement Agreement.

For 17d, DPSCS will have to show:

1. A provider must perform an evaluation of the patient's medication as identified at intake.
2. There needs to be a timely order for necessary medications.
3. The patient *begins* receiving ordered medications within 24 hours.

The YesCare audit continues to only question whether the patient received only a first dose of medication, but the patient must receive more than the first dose to ensure that continuity of medication is verified. To be consistent with DPSCS policy[13] and to be consistent with provision 19.b. administration of medication needs to be properly recorded on a medication administration record. It is a continuing challenge, however, to find medication administration records. Indeed, verification is extremely difficult because medication administration records are not filed in the medical record and the electronic medication administration record is not yet installed.

In the YesCare report, the first dose of medication was verified as given only 61% of the time and the first entire month of medication was not verified at all. This result is about the same as from the last report. A medication administration record was found only 83% of the time which is improved from the last report. I will ask that all medication administration records be scanned to the electronic record. Each month's medication records should be scanned to the last day of the month for the month of activity.

[12] DPSCS Medical Evaluations Manual, Chapter 1 Medical Intake, Section A Initial Medical and Mental Health Screening (IMMS) Part 1
[13] DPSCS Pharmacy and Therapeutics Manual, Chapter 1, Medication Administration (Basics)

The medication administration root cause analysis is still a work in progress. Though problems were identified, corrective actions have not yet been fully implemented or evaluated. A key problem is the disconnect of the pharmacy order system from sally port medication processes and the chaos in the sally port housing unit. Sally port medication is managed by paper medication records which get lost and by logs of patients which are prone to error. The sally port is a very chaotic housing unit where people get "lost"[14], orders and medication records are difficult to locate and are on paper[15], patients are not timely evaluated resulting in late orders[16], failing to identify community medications,[17] problems with diabetics getting timely insulin while on the sally port housing unit,[18]and transfers to housing units from the sally port do not consistently result in medications following the patient to their housing unit.[19] Mostly, this provision is problematic because the paper medication records used to verify administration of medication can't be located. ITCD's effort to implement the electronic MAR is pending. When this is done a significant challenge with be the interface of OCMS to the pharmacy.

The issue with continuity of insulin and other critical medications was addressed in the section 17a.

On record reviews of 20 patients, I identified 7 deficiencies with this provision.

Recommendations:

1. Perform a root cause analysis of the medication process to include intake to identify defective processes and develop corrective actions.
2. Consider placement of an automated medication cabinet in the intake area.
3. Provide the data used to verify receipt of medication for the sample used.
4. Use the medication administration record to verify receipt of medication.
5. All medication administration records (MAR) should be scanned to the electronic record until an electronic MAR is implemented.

Settlement Agreement Statement: 17.e. *The intake screening, any physical or mental health assessment, and any decision regarding the continuation or non-continuation of reported prescription medication shall be documented in the plaintiff's medical record. If a medication is not continued, the clinical justification for that decision shall be documented in the plaintiff's medical record.*

Compliance Rating: Partial Compliance

Findings: DPSCS policy adequately addresses this item. DPSCS did not assert compliance with this item. To verify this item, DPSCS will need to show the following:

1. The IMMS is in the EPHR.

[14] Patient 4
[15] Patient 11
[16] Patient 16
[17] Patient 20
[18] Patients 6, 9
[19] Patient 19

2. The physical health assessment and mental health assessment are present in the EPHR.
3. Any decision regarding medication continuation or discontinuation is documented in the EPHR.

DPSCS has been reporting very high rates of compliance with this audit for several reports but have not asserted compliance[20]. The audit was based on medications identified in the IMMS and determined whether there was an explanation for medications not ordered in the EPHR. The eligible population for the audit assessing documentation of medication was those inmates who reported on the IMMS that they were taking medication prescribed by a physician in the community. If there was an order for this medication, one aspect of the audit was found compliant. However, as documented in the prior report, few inmates who were taking medications or needed medications were actually identified in the IMMS. Most medications were identified in the provider initial history and physical examination not in the nurse intake screening. That said, YesCare noted that 100% of records audited showed a provider order for medications identified by nursing and that 100% of the time there was an explanation in the record for non-ordered medication. This does not include medications identified by the provider.

In record reviews, I found that providers did not document a change in medications for three patients. Two patients[21] had medication changed without any explanation. In both cases there could have been reasonable explanations, but no explanation was provided. It is not clear that intake providers are aware of this responsibility. One patient[22] was at the hospital and had medications recommended. A provider change medications but did not document why the change was made. Though scores on the DPSCS audit are 100%, the data (including patient numbers) supporting the audits must be provided to evaluate their rating and this is not done.

Four recommendations were given in the last report[23]. Recommendation one was not accomplished. A root cause analysis of medication administration was completed but the reason why orders were not resulting in a medication administration record was not included in the analysis. Recommendations 3-4 were not accomplished. No raw data was reported with this provision warranting a continued partial compliance. Recommendation 5 was added because provider do not appear to know this is a responsibility.

Recommendations:

1. Develop an interface so that when a patient is "scanned in", an electronic medical record is opened which would eliminate the need to use the IMMS in OCMS.
2. Perform a root cause analysis to determine why medication orders are not resulting in a medication administration record.
3. Include in the intake root cause analysis identification of why nurses fail to document medications of the patient.

[20] Plaintiffs' counsel commented that the prior report stated that DPSCS didn't provide data for this item so it seems inconsistent to state that DPSCS has been reporting high rates of compliance for several reports. The Monitor reports that data has not been provided and considers that lack of evidence in the scoring.
[21] Patients 4, 18
[22] Patients 19,
[23] April of 2022

4. Provide the raw data used to verify compliance with this provision.
5. Instruct physicians to explain their rationale for any medication change from community or hospital to the jail.

18: MEDICAL PLAN OF CARE

Provision 18 Compliance: Partial Compliance

Settlement Agreement Statement: 18.a. *For purposes of this Settlement Agreement, a "Plan of Care" is a combined summary, evidenced by Clinician documentation in the medical record that includes: (a) a summary listing of major medical problems; and (b) a plan for treatment of such identified major medical problems, including, as applicable, medications, testing, records of past periodic chronic care appointments and access to orders for future periodic chronic care appointments, and access to orders for specialist referral. The Plan of Care shall be documented in the EMR. In the EMR existing as of the Effective Date, the Plan of Care shall be documented utilizing the Chart Summary template.*

Compliance Rating: Partial Compliance

Findings:
This provision requires the following.

- All problems are documented at patient care visits. An accurate list of problems needs to be present in the problem list and in the assessment of every note.
- The history should include review of past care to update the status of the patient's plan of care as well as details of the status of each patient problem.
- There should be an assessment and plan for every problem to include medications, tests, future follow up appointments, scheduling of any referrals for specialty care or diagnostic testing, and updating of pending specialty appointments.

The YesCare report provides a table (SA18: Plan of Care) summarizing record reviews but failed to include the actual data to support the table. The 100% scores for the first five questions on this table are inconsistent with my own or DPSCS's findings in record reviews. In 21 record reviews, I found 61 deficiencies related to provision 18a, DPSCS found 64 deficiencies in four record reviews.

The YesCare table SA 18 documents that for the plan of care 100% of laboratory tests are ordered, evaluated and reviewed. But DPSCS's own data in SA 19E and 19F show that only 61% of lab tests were completed within the timeframe specified in the order; and only 58% of lab tests were reviewed, signed and dated by a provider within two days of the lab test. The SA 18 table documents that 100% of the time, compliance with medication is assessed. It is unclear what this question means but DPSCS documents that medications are administered as ordered only 47% of the time.[24] How can DPSCS score 100% on medication compliance when DPSCS verifies that medications are actually not provided to patients about half the time? Does this mean that providers are ignoring why people do not take or receive their medication? This audit was

[24] Table in 19.b.

discussed in prior reports[25] as being problematic because of chart selection and because the audit did not address requirements of the Settlement Agreement.

The YesCare report also includes four record reviews as qualitative patient case reviews. These reviews are well done and document problems with multiple provisions. These reviews lack corrective actions recommendations, but certainly identify correctible problems referable to multiple provisions including provision 18 that if corrected will create movement towards compliance.

DPSCS is in process of implementing an upgrade to their electronic medical record. The implementation has been ongoing but is incomplete and without a clear end date. This implementation has resulted in a deterioration of the problem list. A major requirement of provision 18 is that a ***plan of care is to be developed for all major medical problems.*** This implies that all medical problems are identified. However, with the recent upgrade of the electronic medical record, the problem list is less accurate than it has been in the past. In my opinion, this is largely because the problem list was not developed by clinical staff but allows open-ended use of the International Classification of Disease codes without any guidance. This will be discussed in provision 24.

There are now three problems lists but the need for three problem lists is not clear. One is labeled the "problem list" and the second is labeled "problem list not yet mapped to SNOMED". These problem lists do not agree with one another. Moreover, neither maps to the assessment list which is the basis for the plan of care. The banner bar also has a tab labeled "problems" which is a third problem list. When the tab is touched with a cursor it produces a dropdown menu of problems which is another problem list that is not the same as the problem lists in the progress note or the assessment. This creates a fundamental defect for provision 18 which, as a baseline, requires that a summary listing of major medical problems be developed for which there is a plan of care for each problem. The existing status is that problems lists are seldom the same from one provider visit to another and the assessments do not include a standard set of problems. This makes provision 18 closer to noncompliance than it has been is several years. The inability of the electronic record to establish an effective and accurate problem list is a barrier to any movement forward with provision 18. This is so fundamental that I urge DPSCS to devote significant attention to ***establishment of a single and accurate problem list*** that maps automatically to the assessment list. This is a medical record issue that has gotten worse with the recent upgrade and will be discussed further in section 24 below.

There were clinical issues with respect to provision 18a that can be reviewed in the record reviews. Based on record reviews, I am adding a strong recommendation to add UpToDate to the software portfolio available when the NextGen product is opened. This should be available to ***all providers in all locations where the medical record is used***. UpToDate is a commonly used electronic resource used in most hospitals, health maintenance organizations, and physician practices that provides up to date clinical information on most medical conditions. It is ideal for a jail environment where providers work typically in isolation and without ability to consult easily with colleagues. It can be loaded on the same server hosting NextGen so that additional devices are unnecessary. Also, providers have lost ability to access Chesapeake Regional Information System

[25] See the May 2022 Report, page 16 under provision 18 for a discussion of this audit.

for our Patients (CRISP) due to not having ability to perform dual authentication. Providers should be allowed to carry cell phones so they can perform dual authentication in order to access CRISP. This has affected ability to identify patient problems and reduces ability of providers to know how patients have been treated in the community.

Recommendations:

1. Emphasize in provider training that for every provider note, for every medical problem there is a history, pertinent examination, assessment and plan pertinent for the episode of care documented in the medical record. When the episode of care is not meant to address every problem, the provider can document that the problem was not addressed.
2. Perform a greater number of record reviews than are now currently being done.
3. Modify chart selection to include higher acuity problems in patients with significant chronic illness and perform open ended audits that address requirements of this decree.
4. Develop rules for the implementation of copy and paste functions to ensure an accurate and meaningful history
5. The implementation of the updated electronic record needs to improve the physician progress note so that information required by providers is easily available in order to produce evidence of a plan of care.
6. ***Fix the problem list***. Develop ***a single accurate problem list that automatically maps to the assessment section***. For each problem placed into the assessment, document the initial or updated plan of care. See provision 24, Medical Records below for additional information.
7. DPSCS should add UpToDate to the software portfolio available when the NextGen product is opened. This should be available to all providers in all locations where the medical record is used.
8. DPSCS should permit cell phones to providers to allow dual authentication so that they can access CRISP.

Settlement Agreement Statement: 18.b. *For purposes of this Settlement Agreement, an "Ongoing Condition" is a condition that requires ongoing care and that: (i) will not be resolved within a 30-day period; or (ii) constitutes a serious acute injury or illness that will require repeated follow-up (aside from routine medication administration) or has lasting significance for the plaintiff's future health care treatment. For those plaintiffs with one or more Ongoing Conditions, a Plan of Care shall be developed by one or more Clinicians, as appropriate, based on physical examination and the documented medical history of the plaintiff, as provided herein.*

Compliance Rating: Partial Compliance

Findings:
DPSCS does not assert compliance with this provision.

This provision requires:

1. A plan of care be developed for all chronic problems and acute problems that require repeated follow up. This is evidenced by an accurate problem list and listing of current active problems in each assessment and plan.

2. The plan of care requires adequate history and physical examination.

This provision also requires an accurate problem list and recommendation 6 of 18.a. must be taken seriously. Record reviews must demonstrate an adequate history and physical examination related to development of the plan of care.

Adequate histories and physical examinations remain problematic as evidenced in the four record reviews completed by DPSCS for this report. DPSCS identified 24 deficiencies in four records reviewed. These record reviews can be reviewed at the end of the YesCare report.

My own record reviews identified 23 deficiencies related to provision 18b largely related to the physical examination. These consisted of providers not performing a necessary examination[26] or using an auto-filled examination that appeared inaccurate[27]. The auto-fill function continues to degrade DPSCS scores as they either fill the note with irrelevant information or worse, sometimes document inaccurate physical examination findings. Examples can be seen in the record reviews.

Recommendations:

1. Only physicians, physician assistants, and nurse practitioners should be authorized to make entries to the medical record problem list.
2. Physicians, physician assistants, and nurse practitioners must maintain the problem list at every chronic illness encounter.
3. The electronic medical record should be capable of automatically providing the current problem list in each provider note. DPSCS should consider auto-populating the assessment section with each current problem of the patient. The provider can then update the plan for each of the current problems and add any additional problems that are missing.
4. A group of BCBIC physicians need to develop:
    a. A standardized methodology to entering problems onto the problem list in the future state electronic record,
    b. Where providers would want the problem list in their notes,
    c. How providers would add or subtract a problem, and
    d. How temporary problems would be presented on the problem list.
5. This methodology needs to be included in requirements for the electronic record for the BCBIC implementation.
6. Create rules so that the autofill function does not result in meaningless or inaccurate physical examinations. Physicians should document examinations only that they actually perform. If the auto-fill function is used, it must be completed accurately.

Settlement Agreement Statement: 18.c. *The Commissioner shall promulgate and implement policy and procedure to ensure that initial diagnosis and identification of Ongoing Conditions, along with any elements of a Plan of Care that do not require development at chronic care clinics or through specialist referral, shall be conducted and entered into the EMR within seven days of the plaintiff's admission, or sooner if clinically indicated.*

[26] See patients 2,5,6, 8,12, 13, 16, 19
[27] See patients 1, 8,16, 19

Compliance Rating: Partial Compliance

Findings:
This provision requires that serious medical conditions that are not chronic care problems must be addressed as soon as clinically indicated. These might include, as examples, detoxification, infections, trauma, orthopedic injuries, etc. Each of these problems should include the following.

- History of the problems.
- Examination pertinent to the problem.
- Assessment of the status of the patient.
- Plan to include follow up, medication, laboratory tests, diagnostic tests, and specialty referral as necessary.
- Follow up until the problem is resolved.

DPSCS does not assert compliance for this provision. DPSCS has a solid detoxification program that reliably performs assessments in intake, follows up on detoxification monitoring, verifies enrollment in medically assisted treatment programs, and initiates treatment with methadone or buprenorphine. Although detoxification is initiated in the sally port there are issues with locating patients mostly when patients move to different housing units. Use of a detoxification housing unit would help significantly. This had been in place earlier but was disrupted due to the COVID pandemic. This program would perform better if there were a detoxification unit to which patients can be directly admitted.

Nurses use nursing notes or a detoxification template to record Clinical Opiate Withdrawal Symptoms (COWS) or Clinical Institute of Withdrawal Assessment (CIWA) monitoring. Often both notes are used and one has to open two notes to evaluate a nurse monitoring visit. A single note is sufficient and a standardized format for documentation should be adopted which would eliminate a 2nd note for daily detoxification monitoring visits by nursing.

COWS and CIWA monitoring is ordered as a generic order but should be specific to the needs of the patient. Generic orders do not describe the providers plan of care specifically which needs to be done. "Drug detoxification monitoring" which is the order I have seen in the orders is an insufficient order. Instead, the interval of testing (twice a day, three times a day, etc.) and test required (COWS or CIWA) should be ordered. In reviewing records, I noticed multiple types of orders for detoxification monitoring . There should be a standardized way to order and report this function.

DPSCS in the YesCare Table 18: Plan of Care, include a question (5th one on the table) that documents100% of records reviewed with episodic recurrent non-serious medical problems have been assessed with a plan of care. The record reviews for this were not provided but need to be provided.

In my own record reviews of 21 patients, I found problems with five patients related to provision 18c. One record was unsatisfactory because the patient[28] had ringing in his ears and the physical

[28] Patient 1

examination was auto-filled and documented as normal but did not include a documented examination of the tympanic membrane despite treating the patient with antibiotics for an infected ear. Another patient[29] placed multiple requests to get vaccinated for COVID, yet I could not find evidence of vaccination. A vaccination summary tab on the banner bar would be useful in this regard. A third patient[30] was seen for an infected finger and treated appropriately with antibiotics. A two day follow up was ordered but not completed. The patient infection worsened requiring hospitalization. A fourth patient[31] was undergoing detoxification and the orders for COWS monitoring was "withdrawal monitoring – alcohol and drugs". This is an unacceptable order as it does not define what monitoring is to occur and at what interval the monitoring is to occur. This results in an inadequate plan of care. The fifth patient[32] was evaluated in sick call wanting to know the status of a prosthesis used for a below knee amputation. The patient said the prosthesis didn't fit any longer. The only examination was to document that the patient had below knee amputation and the only plan was "patient reassured". This did not address the complaint of the patient.

Recommendations:

1 Continue record reviews including for those items that are not chronic care patients.

Settlement Agreement Statement: 18.d. *During this initial diagnosis and identification process, a Clinician shall order that the plaintiff be enrolled in any chronic care clinics that are clinically indicated and recommend any specialty care that is clinically indicated. Any elements of the Plan of Care developed as a result of enrollment in chronic care clinics or specialty care shall be entered promptly in the EMR.*

Compliance Rating: Partial compliance

Findings:

This provision requires the following.

1. All chronic problems be identified and result in enrollment and follow up in chronic care clinics.
2. Problems exceeding the training or capacity to manage onsite are referred to a specialist depending on the nature of the problem.
3. All chronic care is documented in the medical record consistent with documentation of the plan of care.
4. All referrals, status of scheduling specialty care, review of specialty care reports, and modification of the plan of care based on specialty care recommendations are documented in the medication record in the plan of care.
5. Specialty care and hospital reports are present in the medical record.
6. Specialty care occurs timely and as recommended.

[29] Patient 4
[30] Patient 10
[31] Patient 19
[32] Patient 23

DPSCS provided no data in their table SA 18 Plan of Care to address this provision[33]. In my own review of medical records there were 34 deficiencies identified in 21 records related to provision 18d. DPSCS found 11 deficiencies in four records. These consist of a variety of problems with coordination, referral, or management of specialty care needs; ensuring an appropriate evaluation has been done; obtaining records of specialty care reports and ensuring that the progress note documents the follow through of consultant's recommendations. Specific issues related to specialty care are discussed in provision 22 below.

Recommendations:

1. Fix the chronic care list so that it accurately reflects appointments so that chronic care enrollment can be judged against appointments. An alternative method to verify enrollment in clinics can be developed.
2. Verify that specialty care referrals and follow up are documented in the medical record.
3. Provide an accurate specialty care log as recommended for provision 22.
4. Audits[34] performed for this provision need to include the following:
    a. All chronic problems be identified and result in enrollment and follow up in chronic care clinics.
    b. Problems exceeding the training or capacity to manage onsite are referred to a specialist depending on the nature of the problem.
    c. All chronic care is documented in the medical record consistent with documentation of the plan of care.
    d. All referrals, status of scheduling specialty care, review of specialty care reports, and modification of the plan of care based on specialty care recommendations are documented in the medical record in the plan of care as required by provision 22d and DPSCS policy and procedure.
    e. Specialty care and hospital reports are present in the medical record.
    f. Specialty care occurs timely and as recommended.

Settlement Agreement Statement: 18.e. *If an Ongoing Condition is diagnosed and identified after the initial diagnosis and identification, the Plan of Care shall be promptly updated or created, as appropriate, to reflect such new diagnosis and identification.*

Compliance Rating: Partial Compliance

Findings:
The YesCare report documents that, on average, 86% of newly identified chronic care problems are updated to the problem list. This is consistent with the partial compliance rating. The data

[33] Plaintiffs' counsel ask whether this provision should be noncompliant because no data was provided. The YesCare report provides no data for this provision. However, my own record reviews and DPSCS record reviews (not provided as evidence for 18d) provided enough data to warrant a partial compliance rating.
[34] Plaintiffs' counsel ask whether I am recommending that DPSCS perform these audits. DPSCS currently performs all audits. The Monitor reviews data, does spot checking, and performs record reviews.

used to demonstrate this were not provided[35]. The Settlement Agreement requires that the problem list be updated with the plan of care associated with the newly identified problem. The Monitor identified four deficiencies in record reviews related to this provision. However, because the problem lists often changed from visit to visit it was unclear how to score this provision because patients had multiple problem lists that were often inaccurate which if judged on the basis of updating a problem list would substantially lower the score.

Recommendations:

1. None

Settlement Agreement Statement: 18.f. *The Plan of Care shall be accessible to any Medical Professional or Mental Health Professional who is providing treatment, including diagnostic services, to a plaintiff, unless the need for emergency treatment precludes access at the plaintiff's location.*

Compliance Rating: Partial Compliance

Findings: The YesCare report does not evaluate this provision.

For this provision, clinical staff must be able to view the plan of care and it must be understandable to staff in all of its aspects including an accurate problem list, the current provider plan, laboratory results, medications, and future and past specialty care. YesCare provided no data for this provision[36].

A reviewer should be able to read a progress note and identify all of the problems of the patient. For each of the problems there should be an assessment. For each assessment there should be a plan.

Provision 18a states that the plan of care is to be documented utilizing the chart summary template. For that purpose, DPSCS has developed the combined chart summary which can be accessed by clicking the MD Med Chm Home Page. The combined chart summary is a list of 15 links[37] on the left side of the MD Med Chm Home Page. When a link is clicked, a table with information is provided that summarizes data from the record. The data that is contained in the links is meant to be supportive of documenting an appropriate plan of care. This concept is a good one but its implementation has some holes and it appears to have been implemented before it was ready. The data necessary to write the note should be accessible while the provider is writing the note. The links of the combined chart summary should be embedded and visible in the note template providers use so that the provider can access the data **without changing screens**.

[35] Plaintiffs' counsel asks whether a noncompliance rating is warranted since no data was provided. The YesCare report provided no data but my own record reviews demonstrate that a partial compliance rating was warranted.

[36] Plaintiffs' counsel asks whether a noncompliance rating is warranted since no data was provided. My own record reviews of multiple episodes of care show that a partially compliant rating is warranted.

[37] The links are 1) Medical chronic problems 2) Mental Health problems 3) Dental 4) Active Medication 5) Labs 6) past chronic care appointments 7) current/future CC appointments 8) vital signs 9) immunizations 10)allergies 11) referrals 12) consultations 13) seriously mentally ill 14) recent orders 15) PPD results.

Multiple links should be modified and a few should be added.

1. The consultation link lists only approved consultation not all referred consultations; prior referrals are not listed. Denials are not listed. The date the consultation is scheduled is not provided. This explains why providers seldom know when their patients are scheduled for specialty care. This information is specifically called out in provision 22d. This link should include all 1) referrals with the date 2) authorization with the date 3) denials with date 4) alternate treatment plan link 5) scheduled appointment date 6) completed appointment date and 7) link to the scanned copy of the consultation reports.
2. There is no link to capillary blood glucose values but there should be as these tests need to be used to develop the plan of care and are specifically called out in the Settlement Agreement in 19c.
3. The orders link does not appear to contain all orders and it may be helpful to separate orders by types of orders to make searching more effective. This is something DPSCS should get a group of physicians who work at BCBIC to decide. This link needs significant work.
4. There is no link for ADA accommodations and from experience, this information is difficult to find in the record. The orders for ADA accommodations are also not dated with respect to their expiration which may explain why disabled persons have to repeatedly engage the health request system to renew their accommodation. The ADA order should include the order date and the expiration date and should prompt on any user screen an alert when the order is to expire. This should include CPAP, canes, crutches, wheelchairs, catheters, colostomy supplies, etc.
5. There is no detoxification link. Finding detoxification notes, CIWA scores and COW scores is extremely cumbersome and takes considerable time. These tests should be in one place to expedite review and make it more efficient to write detoxification notes. From experience, trying to find this information in the record takes considerable time. A detoxification link should contain a summary or table of all COWS and CIWA scores with their date, time and accompanying vitals. If a graph were included that would be helpful.
6. It is not clear which of the three problem lists is in the Combined Chart Summary or is it a new problem list? Does the problem list automatically open when any provider opens a note or does the provider have to enter it? The problem list needs work.
7. The referrals link is unclear and I wasn't sure what it is for. The one I looked at had orders for a wheelchair. Not sure what this link is for? Its use should be clarified. It appears that referrals, in the past, referred to consultations. But having two different terms to mean the same thing inevitably will result in chaos which is why it is hard for me to find consultation referrals in the electronic record.
8. A link to sick call requests should be present. Clicking the link should list all scanned copies of health requests with the date of request. This will prevent, for example, the ADA nurse from stating that the patient has no problems when the patient has repeated complained about an ADA issue.
9. The dental link is a good idea which gives date of dental visits and a comment on what was done, but dentists still should use the electronic record.
10. The active medication list should list the date of expiration. Provision 19a specifically calls out that medications should be renewed without interruption. But the link requires a provider to click out to another template to determine when medications are going to expire.

11. There is no way to assess on a provider note whether the patient is receiving medication. Until an electronic medication administration record is implemented, all MARs should be scanned to the electronic record and the Combined Chart Summary should have a MAR link so that provider can see all MARS by month of service.

Because the Combined Chart Summary was not implemented well, providers are still not able to document a current plan of care that matches what the actual status of the patient is. This means that to find important and pertinent information providers have to search multiple other locations to write an appropriate note. This implementation needs revision.

Recommendation one was duplicative of a recommendation present in provision 24 and was removed. The second recommendation, now recommendation one, was not effectively done and will need continued effort because much functionality of the record needs revision. A new recommendation is added to make the Combined Chart Summary more effective.

Recommendations:

1. Ensure that the clinical staff leadership at BCBIC participate in the modifications of screens and functionality of the EPHR update so that it can effectively demonstrate compliance with provisions of the Settlement Agreement.
2. Revise the Combined Chart Summary as recommended above.

MEDICATION MANAGEMENT AND TESTING

Provision 19 Compliance: Noncompliance

Settlement Agreement Statement: 19.a. *The Commissioner shall promulgate and implement policy and procedure to ensure that, unless clinically contra-indicated, medications not intended only for short-term use shall be renewed without interruption. Such policy shall ensure that a plaintiff prescribed such medication is seen by a Clinician in sufficient time before renewal would be required for the Clinician to determine whether such medication should be renewed. Nothing in this Settlement Agreement is intended to, or shall, interfere with the exercise of appropriate clinical judgment by a Clinician to prescribe, or not prescribe, any medication.*

Compliance Rating: Partial Compliance

Findings: The DPSCS report does not assert compliance on this provision.

Two factors are necessary to verify this item.

1. One is that necessary medication is continuously renewed.
2. Another is that providers evaluate patients in the renewal process to determine if medication is still needed or should be adjusted.

The YesCare report included an audit that documented 98% of MARs reviewed showed there was continuity of medication without interruption. The score was 81% during the last visit. The data used for this score was not provided. The data needs to be provided[38].

I reviewed three patient MARS and found problems with all three.

One 26 year-old patient[39] was incarcerated 6/19/22. Her IMMS documented "no" to the questions whether she had a medical problem or was on medication. Yet, she had been following with a rheumatologist for a severe collagen vascular disease and was on prednisone and hydroxychloroquine. Medication for her collagen vascular disease was not identified and she lacked continuity of medication for a month.

The patient's medication was initially started because, on 7/12/22, the patient placed a health request stating she needs her medical records ASAP because she was having a lupus flare up. A provider saw her and looked in CRISP and identified that she had Sjogren's syndrome and was followed at a local rheumatology clinic and had been prescribed hydroxychloroquine and prednisone. The doctor confirmed with the pharmacy that this was accurate. The doctor documented she would order a "short course" of prednisone and consider rheumatology referral but the provider did not continue the hydroxychloroquine because the provider was worried about use of the drug during pregnancy.

A provider had apparently initially ordered hydroxychloroquine but on realizing the hydroxychloroquine was contraindicated in pregnancy cancelled the order, but somehow the pharmacy continued to print MARs for this medication for this patient and sent them to BCBIC. This continued for four months. There was no order for this medication in the electronic record medication orders. This implies a dangerous interface problem with the pharmacy– medical record interface that must immediately be corrected as a patient safety risk. The pharmacy was of the impression that the patient was prescribed a medication when she was not. Moreover, this continued for four months. Fortunately, every month nurses reconcile every single medication, because of the defective interface, and identified that the medication was not ordered and did not give the medication. The pharmacy never corrected the problem.

The provider did prescribe the patient's prednisone in July which expired 8/12/22 without anyone noticing and the patient again placed a health request on 8/12/22 because of discontinuity of medication, stating she hadn't been receiving her medication. The prescription was renewed on 8/16/22 and the patient missed about five days of medication.

On 9/20/22 the patient placed another health request stating "I need my prednisone". Her prescription had expired on 9/16/22 without anyone recognizing it. The medication was renewed, but I could not find a progress note in the medical record documenting the renewal. The patient started receiving the medication again on 9/21/22 again having missed five days.

[38] Plaintiffs' counsel ask whether this provision should be noncompliant as no data was provided and because there were problems in all MARs reviewed. While all MARs had problems, my own record reviews demonstrated renewals did occur for many medications.
[39] Patient 20

Two remaining patients were mental health patients. The first patient[40] with severe mental illness had HIV infection. He was sent to a state mental hospital for four months. For the eight remaining months, the patient missed one three-day period of his antiretroviral medications. However, the patient refused medication 96 of the 233 days while in the IMHU. I did not note a mental health-medical conference session to discuss his medication refusals. Although I did not open every progress note I could not verify that providers discussed the refusals with the patient or engage mental health in a conference to promote medication compliance, especially for critical drugs like antiretrovirals in HIV.

For the second patient[41] with mental illness, 11 months of medication records were requested. Only four months of records were sent. Seven of the 11 months of medication administration records were not provided or could not be located. There were gaps in medication for each of the months.

In the past, medication records were not scanned to the electronic record because of insufficient storage space. That apparently has been corrected. However, the electronic medication administration record (MAR) has been delayed and looks to delayed further. Because the electronic MAR is being delayed, all MARs should be scanned to the electronic record. I would suggest to scan these records to the first day of the month for each month of record. This would include sally port MARs.

There has been no change with respect to medication nurses working in the dispensary performing medication reconciliation. During the last visit, they worked standing up in a corridor because they do not have a work space or a chair to sit on. Corridors should be kept free. They apparently still have a tablet computer but I have not been able to confirm this. I have added a recommendation for this problem.

In summary, DPSCS provided a report that showed that 98% of persons receive medication without interruption, but did not provide the data to support this report. Data needs to be provided. This is moved to partial compliance on the basis of the report, but I have considerable skepticism because the data used to derive the score was not provided[42]. I only looked at three records but there were problems in all three records. I have asked for the MARs to be scanned to the electronic record and will be able to verify the audit myself in the future. The data supporting the conclusion in the report must be provided to advance further.

Four recommendations were given in the last report. Regarding recommendation 1, DPSCS provided information that a root cause analysis was completed since the prior report but no further information was provided with respect to corrective actions. Recommendation 2 has been present for some time and I continue to recommend a stop order list. I have been told that NextGen has a two week expiration report that provides a list of medication about to expire within two weeks.

[40] Patient 21
[41] Patient 22
[42] Plaintiffs' counsel asks whether this should be noncompliant since no data was provided. Though there were problems with the MARs reviewed many MARs did demonstrate renewals which warranted partial compliance. I am skeptical of the DPSCS score but based on my own findings and their reported score, I felt a partial compliance rating was warranted.

This can be appropriately parsed and sent to the appropriate provider to renew medications. As well, NextGen should include a notification on the banner bar of the electronic record that medication is about to expire. I have also asked, in section 18f that the Combined Chart Summary add to the medication link the expiration date of all active medications with a link to a renewal form. The remaining two recommendations were not addressed. Three new recommendations were added.

Recommendations:

1. Perform a root cause analysis of the medication renewal process to identify deficiencies and to develop an improved process. As part of this root cause analysis, consider the health request process role in the medication renewal process. Include in the root cause analysis determination of why medication administration records are not all produced by the pharmacy.
2. Consider a stop-order medication renewal backup program to ensure medications are renewed until this item can be improved.
3. Fix the chronic care roster so that it accurately shows appointments or develop in the new electronic record a requirement to accurately show appointments and completed appointments for all appointments including chronic care.
4. Ensure that pharmacy officially maintains the medication administration records and ensure that all nurse written medication administration entries are covered as soon as possible with a pharmacy produced label. The timeframe to overlay a handwritten entry should be no longer than two days.
5. The interface between the pharmacy and OCMS still appears to be defective and must immediately be corrected as it resulted in a significant patient safety risk.
6. Because of the delay in the electronic medication administration record, all paper MARs must be scanned into the electronic record.
7. Identify a location where medication nurses can work. They should have a chair for their work and a desk top that accommodates opening their MAR book as they look patients up.

Settlement Agreement Statement: 19.b. *Medication Administration Records ("MARS") shall be completed by RNs or LPNs. If medication is not administered to the intended plaintiff on a particular occasion, the MARS shall allow a determination whether the medication was refused by the plaintiff or whether some other specified cause prevented administration. Any Medical Professional who makes entries in MARS shall document his or her entries as required by policy, including legibly signing entries, and noting the applicable professional licensure.*

Compliance Rating: Partial Compliance

Findings: DPSCS does not assert compliance with this provision. This provision requires verification of several items including:

- That an LPN or RN administer medication.

- That the nurse document why a patient did not receive medication for all absent doses administered.
- That all entries be documented legibly with licensure noted and that documentation be based on policy requirements.

The YesCare report includes an audit showing that medications were administered as ordered only 47% of the time[43]. This does bring into question the result in 19a that 98% of persons have continuity of medication. A major issue is that DPSCS loses medication administration records.

DPSCS initiated a root cause analysis to determine why missed doses of medication were not documented. There were problems with order changes not reflecting timely to the MAR. The MARS did not transfer with the patient when housing assignment changed. The pharmacy did not know the location of the patient. Multiple corrective actions are being undertaken but it appears that the interface between pharmacy/OCMS/ and the electronic record must be addressed to correct these problems. Corrective actions are underway but presumably the interface is not acknowledged as deficient.

A patient discussed in section 19a demonstrated that the pharmacy produced a MAR for four months without there being an order for the medication in the electronic record. This speaks to a significant patient safety risk which appears to be an interface issue between the pharmacy-OCMS- and the electronic record which must be resolved. This relates to recommendation 4 which is an old recommendation.

I add that on review of three medication records, one of the patient with HIV and severe mental illness refused his HIV medication, which are critical medications, 96 of 233 times. To miss HIV medications risks development of resistant organisms and is dangerous for the patient and the rest of the population. Patients who refuse medication repeatedly should be counseled and DPSCS policy should have a procedure specifying when a nurse is to notify providers when patient refuse medication.

None of the recommendations were completed including number six which was to provide the medication administration records used to verify this provision as an appendix to the DPSCS report. With respect to recommendation 1 to implement an electronic medication administration record, I was told that this would be implemented sometime this spring. I added two recommendations. One is to develop a policy to address medication refusals. A second is to scan all MARs to the electronic record. The date of scanning should be the last date of month.

Recommendations:

1. Obtain a new electronic medical record with electronic medication administration record capacity.

[43] Plaintiffs' counsel asks whether this score warrants a noncompliance rating. DPSCS reported that an LPN or RN administered medication 100% of the time. Missed medications were documented using approved codes 61% of the time. And documentation of nurse initials and licensure was available 67%. I felt that this combination of scores that averaged 69% warranted a partial compliance.

2. Perform a root cause analysis of all areas of medication management including why patient movement results in missing medication.
3. Perform an evaluation of OCMS to determine if an accurate location of the patient is being transmitted to the EPHR.
4. Establish a reliable interface between OCMS and the pharmacy.
5. Until a reliable eMAR is available, ensure that when clinicians see patients, a photocopy of the MAR is available for review. Since this should be in the paper record, it should already be part of DPSCS's requirements.
6. Provide the medication administration records used to verify this provision as an appendix to the DPSCS report.
7. Develop a policy for addressing medication refusals.
8. Scan all MARs to the medical record on the last date of the month.

Settlement Agreement Statement: 19.c. *The Commissioner shall promulgate and implement policy and procedure to ensure that, when a Clinician orders that vital signs or blood sugar results be documented, the documentation occurs as ordered and that these records are reviewed by a Clinician according to appropriate policy.*

Compliance Rating: Noncompliance

Findings: To verify compliance DPSCS needs to show:

1. That vital signs and blood sugar orders are completed
2. That results of vital signs and blood sugar tests are readily available in the EPHR to providers.
3. That providers review these tests and make any necessary adjustments to the plan of care.

DPSCS does not assert compliance with this provision. The YesCare audit of this provision asks four questions.

1. Vital signs completed and documented as ordered in EPHR.
2. Blood sugar tests completed and documented in EPHR as ordered.
3. Vital signs results documented as reviewed by clinician during patient encounter.
4. Blood sugar tests documented as reviewed by clinician during patient encounter.

YesCare reported the average score for this audit was 58%. Vital signs were completed as ordered 45% of the time and blood sugar tests were completed as ordered 49% of the time. In discussion, I have been told that this provision scores low because of problems with the task list. Apparently, there are large backlogs of tasks in the task list. This is a long standing problem related in part to nurses not knowing how to use the task list. This speaks, in part, to a training issue which will be addressed in section 24 Medical Records below.

I did review three patients with diabetes to assess capillary blood glucose (CBG) results. In one patient[44] blood sugars were ordered every morning for three months. The provider wrote this order

[44] Patient 22

in the progress note. This patient was apparently housed on the mental health unit. The order in the order list did not give the length of time of the order. Only one blood sugar was completed over the three months. It is unclear whether this was due to being on a mental health unit.

A second patient[45] had capillary blood glucose ordered on several occasions. I checked 9 weeks of blood sugars. 252 (86%) of 290 expected blood sugars was completed. For a third patient[46] two months of blood sugars was evaluated. Blood sugars were ordered three times a day. 144 (75%) of 192 blood sugars were completed. For both the 2nd and 3rd patient review of the blood sugars was variable but mostly done at chronic clinics. Physicians did not carefully document this review and I encourage medical leadership to encourage physicians monitoring persons with diabetes to document their review of these tests.

Blood glucose results are not included in the links of the Combined Chart Summary. This was discussed in the section 18.

The Combined Chart Summary does not have a detoxification link. This is discussed in section 18f above. There is an associated recommendation for this proposed link.

Scores for this provision are still low and the noncompliance rating is continued.

Four recommendations were given in the last report. With respect to recommendation 1 to obtain a new electronic record, DPSCS did not obtain a new record but did upgrade the existing record. This was ostensibly accomplished December 2022, but the implementation has been incomplete and ineffective. Blood glucose values can be obtained but only after multiple screen changes. Detoxification monitoring data is very difficult to find and is not located in a single screen. I have recommended a link in the Combined Chart Summary for detoxification with a table for all CIWA and COW scores with vitals. Recommendations 2-4 were not addressed. Because vital signs and capillary blood glucose levels are data elements in the medical record, I recommend that DPSCS provide counts of the number of tests done as compared to the expected number of tests based on the order. This may take a specialized query but ITCD should assess whether they can do this as it would verify whether they can obtain and utilize existing data in the electronic record.

Recommendations:

1. Resolve existing bugs in the software to ensure easy accessibility to data on blood glucose levels and vital signs is present. This should include detoxification monitoring results.
2. Perform a root cause analysis of blood sugar and blood pressure ordering with respect to whether the order results in a reliable and functional nursing task list and the extent to which those orders result in the test being performed. This review should also include how a reviewing clinician knows that the prior clinician ordered blood pressure checks or blood glucose testing. As with all recommended root cause analyses, these analyses should inform workflow analysis that is pertinent to the electronic medical record implementation.
3. Review existing policies related to this provision. Make modifications as needed to conform to requirements of this provision.

[45] Patient 23
[46] Patient 24

4. The program should investigate whether the banner bar of the new electronic record can have a prompt that notifies that there are outstanding prior order results that need review. This notice or a similar type of notification specifically for provider records should improve scores.
5. ITCD, or whoever is assigned to obtain data from the electronic record, should attempt to obtain from orders for vitals or blood glucose the number of expected blood sugar tests or vital signs and compare this to the number of tests actually performed to obtain the percent of tests completed. This should be a query that is able to be accomplished.

Settlement Agreement Statement: 19.d. *The Commissioner may require plaintiffs who are prescribed medication that they are permitted to keep on their persons to initiate the process for refill of a prescription medication without having to first see a Medical Professional; provided, however, that DPDS shall have a process for expedited refills of keep-on-person medications that are prescribed for potentially urgent needs, such as rescue inhalers.*

Compliance Rating: Partial Compliance

Findings: DPSCS has not asserted compliance for this provision. The audit should address the following questions:

1. Patients who are on keep-on-person (KOP) have a process for refill of their prescription medication.
2. The process of refill of medication includes an expedited process for refill of medication for urgent needs.

In their audit for this period, DPSCS reported that there was a KOP receipt documented on the medication administration record only 77% of the time on average. This is a significant improvement based on reported scores of 33% in December of 2021 and 43% in September of 2022. However, the supporting data was not provided[47].

DPSCS continues to state that the current electronic record cannot isolate persons on KOP medications as opposed to directly-observed-medication. If the providers are instructed to order medication KOP or DOT then pharmacy is required to include that in the label on the medication administration record. Typically, the prescription order module in the electronic record should include whether the drug is to be administered KOP or directly-observed-therapy (DOT). ITCD should evaluate with medical leadership the order module for medications which appears to be defective if it does not include a KOP designation. I would add that the evaluation of the medication order module should include tapering doses of medication because apparently tapering medication is not permitted. As well, other order sets for some medications are not consistent with contemporary standards of care and may need revision.[48] Apparently, the medication order sets have not been evaluated in the upgrade. This needs to be done.

[47] Plaintiffs' counsel asks whether this should be noncompliant since no data was provided. KOP receipts were documented 77% of the time. This was the basis for the score. That no data was provided is a problem.

[48] ITCD and medical leadership should evaluate treatment of sexually transmitted disease medications versus the contemporary standard of care. Plaintiffs' counsel asked for additional information in this footnote. In a discussion

A root cause analysis of the medication administration process that includes the refill process has not been performed but this should be done.

Four recommendations were made. With respect to recommendation 1, an upgrade of the existing record was implemented in December 2022 but that upgrade was ineffectively implemented and there are numerous bugs and deficiencies that will ultimately result is reworking some functionality. Recommendations 2-4 were not accomplished. Recommendation 4 should have been accomplished with the upgrade if the medication order module was appropriately set up.

A partial compliance was given because of the progress of demonstrating MAR documentation of KOP refills being done. However, the data for this was not provided and further movement on this provision will not be provided if data supporting the report is not provided. One recommendation was added.

Recommendations:

1. Re-assess this provision after implementation of the NextGen upgrade.
2. Perform a root cause analysis on medication renewal in order to describe and improve the current process and to develop a standardized process of medication renewal that is effective.
3. Ensure that current practice is consistent with policy and procedure. Modify policy and especially procedure as necessary.
4. Ensure that providers order medication as KOP or DOT and that pharmacy includes this on the prescription label. This will permit identification of this group in the EPHR.
5. Review order sets for prescription medication. Ensure that tapering doses of medication are permitted. Ensure that order sets include contemporary recommendations including for sexually transmitted disease.

Settlement Agreement Statement: 19.e. *The Commissioner shall promulgate and implement policy and procedure requiring a Clinician to respond to and document in a plaintiff's medical record the results of any ordered tests. Such policy and procedure shall require that a Clinician:*

a. *document review of critical or other serious abnormal values, and any actions taken as a result of that review, within 24 hours of the testing results becoming available, or sooner if clinically indicated, provided that review may be documented by a RN based on telephonic consultation with a Clinician;*

b. *document review of all other ordered testing results within a reasonable timeframe.*

Compliance Rating: Noncompliance

with a provider, I was told that medication for a sexually transmitted disease, based on recent standard of care, was not able to be directly ordered. A workaround was necessary.

Findings: DPSCS has not asserted compliance for this provision. Verification of these provisions require:

1. That the medical record verifies review and documentation of critical or serious abnormal values within 24 hours; and
2. That routine laboratory tests are reviewed within a reasonable timeframe.

Policy on this needs to be reviewed and updated particularly with the implementation of an upgraded electronic record. The YesCare report provided an audit for this provision.

The YesCare audit shows the following results.

- For critical or abnormal test results, the provider was notified timely 86% of the time.
- Patients were notified of normal or abnormal laboratory results only 42% of the time which is unchanged from the previous report.
- Providers documented a timely review of routine laboratory results only 58% of the time.

From a monitoring aspect, there is no means to verify timeliness of laboratory test review except to examine progress notes. Progress notes inconsistently and infrequently document review of laboratory results. Laboratory tests are resulted apparently to the date the phlebotomy occurs which may differ from the date that the laboratory reports results are actually transmitted to the electronic record from the laboratory. A provider can use a module to document review of laboratory tests. However, the verification uses the order list which lists all tests ordered on a particular order. Because laboratory tests may not return on the same date, this module doesn't specify what laboratory test is reviewed or the date of the review. This does not permit verification when and what was reviewed. Dates of the order and phlebotomy can be found with a few screen changes but I could not find the date of review by a provider.

On record review, I found 11 deficiencies with respect to this provision.

The critical laboratory review must be audited manually by searching the electronic record progress notes. For that reason, a log of all critical laboratory tests must be maintained.

Tests performed by the Department of Health are not included in the EPHR laboratory flow sheet.

Recommendations:

1. Maintain a log of all critical laboratory test results.
2. Fix the laboratory results module so it shows the date of review by a provider. If this is a data element it will be able to be searched making verification of this item easy.

Settlement Agreement Statement: 19.f. *The Commissioner shall promulgate and implement policy and procedure to ensure that orders for laboratory testing, including but not limited to cultures of potential Methicillin-Resistant Staphylococcus aureus ("MRSA") infections, are executed within timeframes consistent with the urgency of the test and the capacity of appropriately functioning laboratories to conduct such tests.*

Compliance Rating: Noncompliance

Findings: DPSCS has not asserted compliance for this provision. YesCare performed audits to verify the status of these provisions. Verification of these provisions require:

1. That ordered testing is executed in timeframes appropriate for the urgency of the test;
2. That the laboratory has capacity to perform testing;

These results were said to include MRSA test results but the number of MRSA tests audited was not clarified. Results of the audit were as follows.

- Laboratory tests were completed within the timeframe in the order 61% of the time .
- A hard copy was uploaded to the EPHR within 48 hours 74% of the time.[49]

For this report, I looked at multiple orders but could not find a timeframe when the order was to be completed. For routine blood tests, I would expect blood tests to be done within a week. When the test has a timeframe, the timeframe can be used.

The order summary tab in the medical record has a way to sign off on labs but the date of the sign off is not available. Also, the sign off is related to a laboratory order which may consist of multiple laboratory tests. It is not clear whether the provider is signing off on all tests or some tests. In any case, the date of the review is not provided so the timeliness can't be reviewed. Currently, I have to find verification in the progress note.

There were five recommendations in the prior report. No information was provided that a new interface between the laboratory and the new electronic record was developed by the medical record vendor. I was told that the interface is in place but that apparently results are not directly sent from the laboratory to the electronic record. Instead, some or all lab results go instead to a "holding tank." I was also told that manual intervention is required to assign a lab result to a patient. These "holding tank" results are not present in the patient chart. This is monitored on a regular basis. This is apparently related to patients having duplicate records and the laboratory not knowing into which charts to send the laboratory results. This requires manual intervention to commit lab results to a patients. ITCD is working on a workaround until an OCMS interface is fully deployed which will ostensibly resolve the duplicate patient record issues.

Recommendations 2-5 were not completed. DPSCS needs to adhere to recommendation 3 to send the Monitor the critical laboratory result report so that the Monitor can perform his duties with respect to auditing the Agreement.

Audit results warrant a noncompliance rating.

[49] This audit question is an audit of a work-around due to the EPHR not providing accurate and timely laboratory results to providers which may be an issue in all of these audit questions.

One recommendation was added to identify why ordered laboratory tests are not done. This does not appear to have anything to do with the interface. This appears to be a process problem with the orders or phlebotomist and needs to be determined.

Recommendations:

1. Fix the bidirectional interface between the laboratory and the electronic medical record.
2. Perform a root cause analysis of ordering of all types to identify an effective standardized process of ordering and ensuring that orders are effectively carried out. The audit for this should be based on electronic data in the electronic health record. This analysis should inform a workflow analysis that should be done in conjunction with implementation of the electronic medical record.
3. Provide to the Monitor the critical laboratory result report showing all critical laboratory values prior to the next visit.
4. Evaluate whether the contract laboratory is in any way responsible for these poor results.
5. The audit should separate provider follow up of critical, routine abnormal, and routine normal results.
6. Identify and correct the problem of ordered laboratory tests not getting done.

Settlement Agreement Statement: 19.g. *The Commissioner shall promulgate and implement policy and procedure that defines those blood sugar and vital sign readings that are sufficiently abnormal to require notification of the plaintiff's Clinician; ensure that such policy and procedure for notification is implemented in practice; and further ensure that Medical Professionals notified of such readings take appropriate medical measures in response.*

Compliance Rating: Noncompliance

Findings: DPSCS has not asserted compliance for this provision. YesCare reports findings of an audit for this provision. The provision requires verification of several items including:

1. That policy promulgates appropriate blood sugar and vital sign monitoring guidelines with respect to notification of a provider;
2. That abnormal blood sugar and vital sign results are identified; and
3. That medical professionals take appropriate measures in response.

As noted in the November, 2020 report[50], the DPSCS policy on hypertension and blood glucose testing creates requirements that are clinically inconsistent with current standards of care, are

[50] DPSCS policy on hypertension requires nurses to repeat blood pressure readings for elevations up to 159/99 for three subsequent readings over two month and if still elevated, the patient should be referred to a physician within a month. Patients with blood pressure elevations greater than 160-179 over 100-109 are to be referred to a physician within a month. Patients with blood pressure elevations of 180-209 over 110-119 are to be referred to a physician within a week. Patients with systolic blood pressure over 210 are to be referred to a physician immediately. Systolic blood pressures over 180 are consistent with hypertensive urgency and urgent referral to a provider needs to occur promptly. Referral of patients with blood pressures as high as 160-179 over 100 to 109 in a month without any other context is also not a safe guideline and should be revised. I was told by physician staff that, in practice at the jail, *any* abnormal blood pressure is referred to a provider. No guidelines are provided in the DPSCS policy on hypertension with respect to provider ordering of routine blood pressure checks. But, the DPSCS policy requires that when nurses

confusing, or lack sufficient detail. This should be addressed and the policy and procedure should be revised. This has been recommended since November of 2020 but has not yet been done. If the policy issues are not addressed, then the audit will be measuring data that is not clinically appropriate or requires unnecessary work.

There are six questions in the YesCare audit for this item.

1. There is an order *with parameters* when providers order vital signs or blood sugar results. This score was 32%.
2. There is documentation that the tests were performed based on the order. This score decreased to 35%.
3. Abnormal results are referred to a provider. The score for this item was 43%.
4. There is documentation of review by a clinician after referral from the nurse. This score improved to 71%.
5. Blood sugar tests are reviewed by the provider. This score was 79%.
6. There is an abnormal A1c level > 9% and it is reviewed. This occurred 100% of the time.

These are very poor results and indicate a significant problem with orders for clinical testing and follow up of results of testing. A root cause analysis was recommended but not yet done.

Four recommendations were given in the last report. For recommendations one and three, DPSCS states that YesCare and DPSCS have worked to modify thresholds for reporting abnormal vital signs and blood glucose levels, but no modified procedure has been provided in their report or provided to the Monitor. Also, no evidence has been provided that policy and procedure have been modified. Recommendations two and four were not undertaken.

---

perform routine blood pressure checks the results are to be documented in the medical record. Routine blood pressure checks are equivalent to ambulatory blood pressure monitoring and in jails can usually be significantly reduced in number by calling the patient back for a subsequent provider visit for an abnormal blood pressure. Unwise overuse of routine nursing blood pressure checks can dramatically raise the task list of nurse to unsustainable level without clinical benefit.

The DPSCS policy on diabetes is confusing. It requires persons initiated on insulin to be monitored daily until glucose is stabilized and once stabilized capillary blood glucose testing is to be done two to three times weekly. The term "monitored daily" is not clearly defined. By DPSCS policy, patients with type 1 diabetes are required to be tested at least twice daily until tight control has been established. DPSCS provides no recommendations on blood glucose testing after tight control is established. There are no recommendations for self-monitored blood glucose testing for type 2 diabetes whether on or not on insulin. These DPSCS recommendations are inconsistent with recommendations on self-monitored blood glucose testing from the American Diabetes Association and contemporary standards and should be reviewed and revised.

With respect to notifications, the DPSCS diabetes policy requires the treating physician to specify the range of blood glucose values for which a nurse notifies a provider. Typically, correctional facilities establish set guidelines of blood sugar values for which nurses must notify a physician. Physicians can modify the parameters for specific patients if needed. To have physicians establish parameters for every patient creates unnecessary work and, in practice, is seldom done.

Recommendations:

1. Standardize thresholds for nurses to notify providers for both blood pressure values and blood glucose values allowing for modifications as needed.
2. Fix medical record issues so that reportable results are queued to the responsible physician.
3. Review and revise, as indicated, the hypertension and diabetes policies to be consistent with contemporary standards and to improve effectiveness of clinical care.
4. Perform a root cause analysis on the process of blood glucose testing and blood pressure checks to develop an improved system that supports clinical needs.

INTERACTION BETWEEN MEDICAL AND CUSTODY

Provision 20 Compliance: Partial Compliance

Settlement Agreement Statement: 20.a. *The Commissioner shall promulgate and implement policy and procedure for coordination between custody and medical staff to ensure that custody staff transport plaintiffs to emergency and scheduled internal and off-site appointments with Medical Professionals and Mental Health Professionals, for other specialty appointments, and for medical tests. Such policy and procedures shall also be promulgated and implemented ensuring timely rescheduling of missed appointments.*

Compliance Rating: Partial Compliance

Findings: DPSCS has not asserted compliance for this issue. This issue requires the following.

1. That there is policy describing coordination between custody and medical staff regarding medical appointments;
2. That **all** appointments, onsite, offsite, emergency and routine for all types of appointments are scheduled and transported to their appointment.
3. That persons who miss their appointment are timely rescheduled.

The policies[51] provided to me as pertinent to this provision do not address this provision in its entirety. The Interagency Agreement which was not presented to me as pertinent to this provision

[51] 1) YesCare Health Utilization Management Manual 2017. This utilization manual does not address scheduling processes at BCBIC. 2) DPSCS Directive Number DPDS 110.0007 Urgent and Emergent Medical Transport. This policy addresses movement of inmates for emergencies but not for routine scheduled appointments. 3) DPSCS Medical Evaluations Manual Chapter 4 Emergency Services, Section A Emergency Services. This policy addresses only emergency transportation. 4) DPSCS Sick Call Manual, Chapter 1 Sick Call. Aside from the statement that the sick call schedule is to be provided to ACOM (custody?) a week prior to start of any month and the schedule must be published no later than 5 days before the first day of the month, this fails to address sick call slips which must be scheduled within 24 hours of receipt.

addresses sick call coordination between custody and medical[52] but only for sick call. The DPSCS Interagency Policy on sick call states in item 13 under responsibilities of the medical staff,

> "The Office of Clinical Services will coordinate obtaining all scheduling data after clinics have been concluded and summarize these data to show: the number of appointments scheduled; the number of patients who showed up and were seen for their appointments; the number of patients who were not seen; and the reasons for not showing up for those not seen. These summary data shall be presented [and] maintained on a monthly basis and provided quarterly to the quality improvement program".

The data required for sick call, should be replicated for all scheduled appointments and used for verification of this item. Instead, DPSCS continues to sample 33 patients a month *who only have specialty or off-site appointments*. This does not verify compliance with this provision of the Settlement Agreement. ***Any and all*** scheduled appointments need to be included.

This includes as examples:

- Medical health requests including face-to-face encounters,
- Dental health requests,
- Mental health requests[53],
- All other dental appointments,
- All other mental health appointments,
- Nurse follow ups, dressing changes, etc.
- All types of provider visits,
- Phlebotomy for laboratory tests,
- Internal specialty care consultations,
- Off-site testing and specialty consultations
- Emergency room visits.
- Vital sign assessments
- CIWA and COWs evaluations

The audit of scheduled specialty care appointments provided by DPSCS shows the following:

1. 95% of offsite consultations are ordered[54]. How can an offsite consultation occur that is not ordered? Is this question meaningful?
2. 78% of consultations or tests have a report or test result in the electronic record.[55]

---

[52] Interagency Agreement between YesCare Health and Maryland Department of Pre-Trial and Detention Services Baltimore Central Booking and Intake Center (BCBIC) in accordance with the Duvall Settlement Agreement Provision 20, Interaction Between Medical and Custody and Provision 23 Sick Call, July 2019

[53] This was discussed with Dr. Metzner who agreed that mental health requests and appointments should be tracked. Both Dr. Metzner and I will be interested in the "no show rate" and why patients do not show for their appointments.

[54] I do not find this to be consistent with my record reviews. Refer to the record review attachment for details of specialty orders.

[55] Many consultation reports that are placed in the medical record are not consultation reports but only after-visit summaries which do not give clinical information regarding the consultation or hospitalization. These should not be counted as consultation reports.

3. When patients go to an emergency room there is a review of the emergency room report 100% of the time.[56]
4. For missed appointments, there is a documented reason for the missed appointment 78% of the time.
5. For missed appointments, there is documentation of a rescheduled and then completed appointment 55% of the time.

This audit has actionable information but does not pertain to the requirements of this provision of the Settlement Agreement. A partial compliance rating has been given on the basis of having an Interagency Agreement consistent with needs of part of this provision and evaluation of only a small sample of selected appointments. Also, the audit fails, except for a small subset of appointments, to judge DPSCS's progress toward compliance with this provision of the Settlement Agreement.

DPSCS is attempting to implement the EPM scheduling system to schedule all appointment but apparently YesCare is unable to get all of its staff to use this scheduling program.

Four recommendations were given in the last report. The first two recommendations were not addressed. DPSCS has initiated the 3rd recommendation but this is in the early phase of development. The 4th recommendation was to provide policy on this provision, which is not only a recommendation of the Monitor but is a requirement of the Settlement Agreement. That has not yet been completed. The Interagency Agreement on sick call addresses the scheduling and monitoring of sick call appointments. However, the Settlement Agreement requires policy and procedure be developed and implemented to satisfy all requirements of this provision of the Settlement Agreement. That still remains to be done.

Recommendations:

1. Maintain a tracking log of **all onsite** appointments to include:
    a. Appointment date,
    b. Whether the patient shows up and is seen for the appointment, and
    c. If the patient doesn't show up why the patient didn't show up.
    d. Reschedule date if the patient was a no show with show or no show and reason for no show. Repeat this until appointment completed.
2. Perform a root cause analysis of scheduling so that a standardized process can be developed to schedule and track all appointments. This should inform the workflow for scheduling that should be used in the implementation of the electronic record.
3. Standardize the scheduling process.
4. Provide the policies relevant to this provision.

Settlement Agreement Statement: 20.b. *The Commissioner shall promulgate and implement policy and procedure to ensure that when Medical Professionals or Mental Health Professionals direct medical accommodations (such as bottom bunk placement, access to a cane or crutches, specialized housing for medical or mental health purposes, or for purposes of protection from*

[56] Hospital emergency room reports also mostly consist of after-visit summaries which should not count as a hospital report.

exposure to excessive heat), custody staff follow such directives. In the event that custody staff have concerns about the security implications of a particular medical accommodation, a mechanism shall exist to resolve such concerns promptly in a manner that does not threaten the health or safety of the plaintiff whose accommodation is at issue.

Compliance Rating: Partial Compliance

Findings: DPSCS asserts compliance for this provision.

Requirements for this provision are:

- DPSCS is to have policy that custody is to honor orders for equipment, supplies, or housing accommodation.
- DPSCS practice can be shown to act in accordance with the policy.
- A mechanism is in place to address custody concerns about security implications of an accommodation and to resolve the concern without adversely affecting the patient's health or safety.

Findings in this report uncovered problems with a DPSCS policy[57] and a DPDS directive[58]. The DPDS directive provided for this provision does not address housing or supplies; it should. The DPDS directive also does not stipulate a timeframe of custody honoring housing orders that involve an accommodation (infirmary, ADA housing, or low bunk). Neither the DPSCS policy or the DPDS directive describe a procedure that provides a mechanism to address security concerns when custody has concerns about an accommodation. The policy and directive should be revised to address these issues. Recommendations are given for this.

YesCare audited this provision. A monthly sample size of 40 individuals was used. The audit includes the following questions.

1. There is an order in the EPHR for any ADA accommodation. The score for this averaged 99%.
2. There is a completed transfer of housing form in the EPHR. The score for this was 96%.
3. Detainees are housed in designated ADA housing. Scores for this audit question averaged 97%. This audit question should be rephrased to ask whether detainees are housed in ordered housing.
4. There is a signed receipt for durable medical equipment. Scores for this averaged 83%.

DPSCS asserted compliance for this provision. The scores are improved but only 83% of durable medical equipment is signed as received. Record reviews attached to this report identified 13 deficiencies in provision 20b in twenty one records. Based on the findings in these record reviews, and the scoring in the report this provision is not quite compliant. The YesCare audit should be revised to address new findings.

[57] DPSCS Policy Chapter 6 Inmates with Special Needs
[58] DPDS directive DPDS.130.0009 Medical Autonomy

Persons who may need infirmary housing due to their disability should be promptly evaluated by a provider and a housing decision made. Housing on the infirmary and on ADA units should be by provider admissions and these should be clearly documented on the health assessment form. Custody should honor ADA housing admissions and promptly move people to their assigned housing. Pending any movement, there should be an ADA check of any person with disability who remains in the sally port for longer than 8 hours after an order to house the patient elsewhere. A performance metric should be instituted that no person with a significant disability is housed in the sally port especially those requiring infirmary housing. All of these decisions and actions need to be documented on the IMMS and health assessment forms as appropriate.

There was one case[59] where a low bunk and cane were not provided after a patient transferred housing units. Custody took the patient's cane for security reasons and the patient was not in a low bunk. This case should be investigated. This is addressed in detail is the section for 21b below. An additional recommendation is given for this provision to address the policy aspect of this issue. The revision to procedure needs to include what the Settlement Agreement requires which is "a mechanism shall exist to resolve such concerns promptly in a manner that does not threaten the health or safety of the plaintiff whose accommodation is at issue". This is discussed in 21b below. The new recommendation 5 to revise policy and a DPDS directive addresses this issue.

There were three recommendations in the prior report. These are modified given new findings and changes to the medical record.

The first recommendation given in the last report was to fix the order system in the electronic record so that orders for accommodation can be written into the electronic record. This is accomplished. There is now an implemented order system as well as an interface between OCMS and NextGen. OCMS has the location of inmates to the bed which gives information that describes who is in a low bunk, in the infirmary or in a specialized ADA unit. Because these electronic record functions are now in place, the first recommendation is revised. ITCD should initiate a monthly audit to compare orders for low bunks, ADA housing, and infirmary housing (from NextGen data) with the actual housing location (from OCMS) to determine the number and percent of persons who are appropriately housed. Orders for ADA equipment and supplies (from NextGen) should be compared with the signed receipt for the supply (from NextGen) and date stamps (from NextGen) to determine the number and percent of persons who receive their ordered equipment and supplies no later than 24 hours. These data should be produced monthly and provided to the Chief of Compliance and the Director of Duvall Compliance.

The second recommendation to develop corrective actions related to a process analysis of the ADA population has been initiated. Results of the corrective actions are not yet known. This will be discussed further in section 21a below.

A 3rd recommendation in the last report was to audit persons on the ADA units and infirmary separately from general population. This has not been done. Because ITCD has implemented

[59] Patient 15

an upgrade of the electronic record, I revised recommendation 1 that will make the prior recommendation 3 unnecessary.

New recommendations were added to revise a DPSCS policy and DPDS directive as described above. Recommendation two was moved to 21a.

Recommendations:

1. DPSCS should obtain 1) all ADA supply, equipment, and housing orders from the electronic record; 2) housing data from OCMS; and 3) receipt of equipment and supply data from the electronic record. These data should be used to on a monthly basis to show 1) the number and percent of persons who are appropriately housed including for low bunks and 2) who receive their equipment and supplies within 24 hours. This recommendation is repeated in 21a because it applies to both provisions.
2. Expanded procedures, including for the sally port, on how to implement DPSCS policy[60] specifically for BCBIC on providing accommodations beginning in the sally port need to be developed.
3. DPSCS directive on Medical Autonomy Division of Pretrial Detention and Services Directive DPDS.130.0009 should be revised to include housing and supplies that are ordered to accommodate a disability.
4. Both DPDS.130.0009 and DPSCS policy on Inmates with Special Needs need to be revised to include a written procedure for how to resolve issues that involve custody not carrying out an order for an accommodation. This includes changing low bunk orders when a patient transfers, removing durable medical equipment by custody (taking canes or crutches), not promptly sending a patient to the infirmary or to an ADA housing unit, etc. The report section for provision 21b has additional detail. But this should involve the ADA nurse, the custody-assigned ADA coordinator and designee of the Warden. Any resolution of the problem for removal of an accommodation needs to be brought to the attention of the DPSCS Medical Director or designee who should intervene when the decision is inappropriate clinically.
5. The DPDS.130.0009 directive should also be revised to include a timeframe to undertake ordered housing assignments with respect to disabilities which include transfer to the infirmary or ADA housing from the sally port or general population housing.

Settlement Agreement Statement: 20.c. *The Commissioner shall ensure that Medical Professionals and Mental Health Professionals have access to current plaintiff location information for all plaintiffs on at least a daily basis.*

Compliance Rating: Partial Compliance

Findings:

[60] DPSCS Medical Evaluations Manual, Chapter 6, Inmates with Special Needs

DPSCS asserts compliance on this provision. The YesCare report does state that health care staff are granted OCMS access and have an alpha list of all patients with their locations which has been verified. Current finding suggest that this is insufficient.

Record reviews and the DPSCS MAR study also demonstrate that staff do not always know where the patient is housed. The most troubling is that patients *in the* sally port are not always able to be located and it appears that patients are "lost" in the sally port. On one record review, a nurse tried to medicate a patient[61] in the sally port but the medication officer told the nurse that the patient couldn't be located. The nurse wrote, "Traffic was called and per traffic @0617 the traffic officer stated pt was here somewhere on the booking floor despite my efforts pt wasn't seen and the medication officer could no longer be located". This problem in the sally port must be corrected as it impairs ability to effectively manage health problem. Where can a person be housed in the sally port such that they cannot be located? A separate case involved a transfer. A nurse attempted to perform a COWS test on a patient[62] but could not locate the patient for three separate attempts over a twelve hour period. This patient was being moved from the sally port to housing on 4N. On the last two attempts the nurse went to the unit where the patient was housed but was told he wasn't there. Custody and medical should work out a way to correct these two types of problems and especially the problem in the sally port.

I have talked to multiple staff who also have difficulty finding where patients are housed. The interface between OCMS and the electronic record is complete so the precise location of the patient should be able to be presented in the medical record updated whenever OCMS updates the location. Some records I reviewed have a building location of the inmates that prints on the progress note but other records have no housing location. The reason for this is not clear to me. The precise housing location needs to be present in the medical record and present on progress notes. Because the OCMS and electronic record interface is complete, all progress notes and templates should show the precise OCMS current location to the bed which would inform as to whether the patient is in a low bunk or on an appropriate housing unit. That the electronic record does not include this information causes all sorts of problems with medications and with providers not knowing where patients are housed.

I have been told by some staff that that sometimes the location of the patient is inaccurate. This may reflect an interface issue between OCMS and NextGen but may be a result of inaccurate housing information in OCMS.

For compliance, DPSCS needs to ensure that NextGen has the accurate OCMS housing data to the bed and that NextGen places this data on banner bar of the EPHR and on the printed progress notes for all patients.

Recommendations:

1. Ensure that the NextGen update includes the location of the inmate on the banner bar and is present on all progress notes. The location should be to the bed including whether it is a top or bottom bunk.

[61] Patient 4
[62] Patient 19

2. Ensure that OCMS location is accurate.

Settlement Agreement Statement: 20.d. *The Commissioner shall promulgate and implement policy and procedure to ensure coordination between custody staff and Medical Professionals when scheduling sick call and medication administration.*

Compliance Rating: Partial Compliance

Findings: DPSCS asserts compliance for this item. Policies for this item are the interagency agreements with respect to medication administration and sick call which have been completed.[63] These interagency agreements are adequate so policy is adequate.

The YesCare report provides no data to verify this provision[64]. With respect to sick call, DPSCS describes the collaboration between custody and medical and provides no further data because provision 23 was deemed compliant. I don't disagree.

The remaining issue is verification that there is collaboration on medication administration. The Monitor gave recommendation #4 in the prior report to use the required steps in the Interagency Agreement to audit medication administration.

For the last report, custody and medical performed a weekly combined audit. The audit consists of 14 custody questions and 18 medical questions that are consistent with the procedures for custody and medical as promulgated in the interagency agreement. A supervisory officer and nurse accompany a nurse during medication administration alternating nurses and housing units reviewed to ensure that all housing units are reviewed periodically. The supervisory personnel answer their respective questions as compliant or noncompliant. Audit results were requested but not provided in the DPSCS or YesCare reports but were provided after the tour upon request. I ask that both custody and medical perform a brief counseling after the event with the respective custody or nurse employee to counsel on appropriate adherence to procedure if a deficiency was identified. Whether a deficiency was identified or not the supervisor should review the audit with the employee and have the employee sign the audit as well. No evidence of this was provided.

The summary audit data of nursing personnel showed compliance for 97% of applicable questions.[65] For custody, the average score for applicable questions was 85%[66]. Scores for

[63] Interagency Agreement between YesCare Health and Maryland Division of Pretrial Detention and Services Baltimore Central Booking and Intake Center (BCBIC) for Conducting Medication Administration in accordance with the Duvall Settlement Agreement; Provision 20: Interaction Between Medical and Custody and Provision 19: Medication Management and Testing and Interagency Agreement between YesCare Health and Maryland Department of Pre-Trial and Detention Services Baltimore Central Booking and Intake Center (BCBIC) in accordance with the Duvall Settlement Agreement Provision 20, Interaction Between Medical and Custody and Provision 23 Sick Call, July 2019

[64] Data was provided post-tour which resulted in a revision of this section.

[65] Some questions (e.g., whether a keep-on-person medication was administered) were not applicable to the patients being administered medication.

[66] I calculated these scores and excluded non-applicable responses.

custody improved over time. Medical scores were consistent with compliance but custody scores remain partially compliant. I am encouraged by the improvement in custody scores. In subsequent reports, all data pertinent to all provisions needs to be provided. The medication audits need to continue and results need to be provided with DPSCS's report.

Recommendations:

1. Verify that the interagency agreement procedure for medication administration is being followed.
2. Verification of adherence to the sick call procedure can be verified by show rates to sick calls for the various discipline.
3. Ensure that sick call for all disciplines are tracked and reported similar to provision 20a.
4. Using the required steps for medication administration for both custody and nursing staff as represented in the interagency agreement, develop a checklist of required steps. A custody and nursing supervisory staff should monthly audit medication administration of one nurse's medication rounds and ensure that all steps are completed as required in accordance with the interagency agreement. A different nurse and jail location should be chosen every month to ensure that all areas and shifts are audited consecutively. **The audit form results should be discussed between the supervisory staff with the employee audited and the employee should sign the form of the signed audit as well as the supervisors to ensure that feedback has been given to the employee.**
5. Provide the audits performed for item 4.

Settlement Agreement Statement: 20.e. *The Commissioner shall promulgate and implement policy and procedure to ensure that plaintiffs classified as H1 are housed in temperature-controlled housing, to the extent sufficient temperature controlled housing is available, from May 1 through September 30. Temperature-controlled housing includes those housing units of BCBIC, WDC, JI Dorms 600 and 700, and such other facilities as the parties agree constitute temperature-controlled housing because such units reliably control temperature to less than 88˚Fahrenheit.*

Compliance Rating: Substantial Compliance

Findings: All parts of the jail are now air conditioned and therefore this provision is no longer pertinent to current conditions. The recent Plaintiffs' visit to the infirmary unit included evidence that the infirmary was not properly air conditioned. Room 407 was 79.3 degrees with 58% humidity yielding a heat index of 81 for which a health caution is applied. While the Settlement Agreement requires moving inmates when the temperature exceeds 88 degrees Fahrenheit, the infirmary unit houses higher acuity patients for whom high temperatures, including at this level, increase risk. On clinical grounds, this should be corrected.

Recommendations:

1. None

Settlement Agreement Statement: 20.f. *In the event that the temperature control system of a housing unit used for H1 plaintiffs fails to maintain the temperature below 88˚Fahrenheit, the*

Commissioner shall, to the extent possible and safe, transfer such H1 plaintiffs to other H1 housing. If insufficient H1 housing is available, appropriate Clinicians shall determine which HI plaintiffs are priorities for transfer to the available H1 housing. Respite in air-conditioned areas shall be provided for such plaintiffs, as well as other plaintiffs as required pursuant to Maryland Division of Pretrial Services, Directive 185.008 (2009).

Compliance Rating: Substantial Compliance

Findings: All parts of the jail are now air conditioned and therefore this provision is no longer pertinent to current conditions

Recommendations:

Settlement Agreement Statement: 20.g. *In the event that any housing unit designated as temperature controlled fails to reliably control temperature to less than 88˚Fahrenheit while plaintiffs designated as H1 are housed there, such housing unit shall no longer be considered temperature-controlled housing for purposes of this Settlement Agreement until the Commissioner provides evidence that such housing can now be expected to reliably control temperature to less than 88˚Fahrenheit under comparable conditions in the future.*

Compliance Rating: Substantial Compliance

Findings: All parts of the jail are now air conditioned and therefore this provision is no longer pertinent to current conditions

Recommendations:

ACCOMMODATION FOR PLAINTIFFS WITH DISABILITIES

Provision 21 Compliance: Partial Compliance

Settlement Agreement Statement: 21.a. *The Commissioner shall promulgate and implement policy and procedure ensuring the timely delivery of necessary medical supplies to plaintiffs with disabilities. The Commissioner shall promulgate and implement policy and procedure to ensure that plaintiffs with disabilities that require special accommodations are housed in locations that provide those accommodations, including, as applicable, toilets that can be used without staff assistance, accessible showers, and areas providing appropriate privacy and sanitation for bowel disimpaction.*

Compliance Rating: Partial Compliance

Findings: DPSCS asserts compliance on this item.

To obtain compliance, DPSCS must ensure the following:

1. There must be policy and procedure implemented to address this Settlement Agreement provision.

2. Persons with a disability requiring an accommodation timely receive supplies and an accommodation including appropriate housing, equipment, supplies, toilets, showers, and toileting needs.

DPSCS policy[67] is dated and needs revision. The responsibility of the nurse, particularly in the sally port during IMMS, in identification of a disability and the subsequent disposition by the nurse needs to be stated. It is not now addressed. The provider must order an accommodation but when a nurse in intake identifies a disability need that needs prompt attention to avoid risk, that need must be promptly addressed by way of obtaining orders from a provider or having a provider promptly evaluate the inmate. The procedure also doesn't give timelines for providing equipment or supplies or for moving patients to appropriate housing.

DPSCS provides data for this provision in the YesCare report which shows that though DPSCS asserts compliance, their scores are not yet consistent with a compliance rating. Their scores are as follows.

1. There is an order in EPHR for medical supplies. Scores for this item averaged 100%.
2. There is a copy of a disability assessment form in the EPHR. Scores for this item averaged 82%.
3. There is a copy of a signed receipt for medical supplies. Scores for this item averaged 73%
4. Initial supplies were provided within 12-24 hours of the order. Scores for this item averaged 56%.
5. Subsequent supplies were provided consistent with protocol. Scores for this item averaged 89%.
6. There is a transfer of housing form in the EPHR. Scores for this item averaged 86%.
7. Detainees listed on the ADA log are housed in designated areas. Scores for this item averaged 94%.

These scores do not merit a compliance rating. Only 56% of persons timely receive their supplies and for only 73% of persons is there evidence that they received their supplies. The audit does not include any question as to whether the housing accommodation satisfies the Settlement Agreement requirements to provide the necessary accommodations required by the disabled person (toilets, showers, grab bars, beds, etc.). This can be audited by environmental rounds on ADA units to ensure that toilets and showers meet all ADA criteria and that showers have appropriate access, hot water, and water sprays conducive to a wash. There is no routine audit of physical space, equipment, and accommodations for the disabled but such an audit should be included in DPSCS's audit (see recommendation five below).

DPSCS policy requires that the initial examination shall identify any physical or mental disability. But for providers, the decision to provide an accommodation is not consistently based on an adequate examination. Some individuals with mobility disability need physical examinations only but others need functional assessments to determine what type of

[67] DPSCS Medical Evaluations Manual, Chapter 6 Inmates with Special Needs

accommodation is necessary. Some disability assessments are made even without a physical examination. These are not objectively based. Provider performance needs to improve.

Physical examination for mobility disability should be prefaced by asking the patient if they have ever or recently fallen. A brief history to determine if the patient has had memory or cognitive issues should be done for selected patients. For those at risk of mobility disability, examination should include observing the gait for whether the heels clear the floor, whether the gait is symmetric without swaying and whether path deviation does not occur. Gait speed should be noted as extremely slow gaits indicate abnormality and greater risk for falls. Balance can be tested having the patient stand with feet in tandem, semi-tandem, and side by side; testing patient's stability during a 360 turn; and testing muscle strength of all extremities. For the few elderly patients with any memory problems or with significant disability, referral should be made to a physical therapist or occupational therapist who can perform a thorough functional evaluation of activities of daily living. These examinations should not be auto-filled. A judgment call is necessary with respect to what type of equipment is necessary. But as soon as a disability is identified, the accommodation should be provided. Equipment should be available for this purpose.

In a small subset of patients, a more detailed functional mobility assessment is needed. These are individuals who have had a fall in the past, who state they cannot manage their activity of daily living on their own, who have significant mobility disability or have memory or cognitive issues. These select and few individuals should be referred to a physical therapist who is trained in performing functional assessments of ability to perform activities of daily living.

There were a couple patients[68] in record review who had cognitive issues which were not evaluated adequately. For elderly patients or any patient with a potential memory or cognitive issue, a more thorough examination should be performed. I strongly discourage the auto-filled examinations that many times appear to be inaccurate. UpToDate is a good resource for this evaluation and they recommend using the Mini-Mental State Examination (MMSE) or the Montreal Cognitive Assessment (MoCA). These tests are not complicated and can be done in the clinic examination room. If a person does have positive findings on one of these tests more advanced neuropsychiatric testing should be done.

The purpose of the physical examination, functional assessment, and cognitive assessment is protection of the inmate and reduction of pain and harm. Some patients, like one I saw on tour,[69] need protection because due to their cognitive issues are vulnerable to being preyed upon or understanding how to cope in the environment. These patients need protected housing. Persons with mobility functional deficits need accommodations to reduce pain and prevent falls and injuries and to facilitate capacity to conduct activities of daily living.

[68] Patient 3 had memory deficits; patient 19 had cognitive issues from traumatic brain injury.
[69] Patient 19

DPSCS performed a medical record audit of ADA patients[70] that had multiple findings. These findings included:

1. Nurses performing the IMMS and providers performing the initial intake assessment did not have similar ADA findings in their evaluations of patients.
2. Durable medical equipment forms were not consistently signed by inmates that they had received equipment and supplies.
3. There was a lack of electronic medical record features to integrate or flag pending tasks to inform staff of the needs of disabled.
4. Forms and other paper documents were missing when patient transferred between housing units.
5. Paper forms used for disabled needs were not easily accessible.
6. ADA needs are not identified in intake as required by policy.
7. Unauthorized forms are in use.

These findings pointed out the differences between the IMMS screening and subsequent provider evaluations. Because there is a delay from the IMMS until a provider examines a patient that can last for hours or up to a day, nurses must perform an assessment. The IMMS nurse screening is question-based and does not currently include a nursing assessment based on nursing assessment skills and observation. Nurses merely perform a questionnaire and refer patients for an urgent provider evaluation, but this causes a delay in receiving a necessary accommodation to prevent risk.

DPSCS completed an Intake ADA root cause analysis and confirmed that provider orders in intake were not present even when nurses were providing accommodation. DPSCS is initiating corrective actions. More improvements are needed with respect to the initial identification and receipt of an accommodation which involves sally port processes.

DPSCS has provided screen-shots of a proposed new IMMS form that will help improve nurse IMMS screening. That new form includes a Physical Limitations template that asks four questions and has a comment box. I would add a question, "Do you care for yourself at home or do you need someone to help you with any activity". The IMMS does not include a nurse assessment and in the section on 17a , I proposed adding a section on the IMMS for a nurse assessment. The Nurse IMMS Medical and MH Disposition template page on the new form has no disposition for persons with disability. The nurse is assigned no responsibility in this process and by policy can't order any accommodation. Therefore, nurses performing the IMMS should include a nursing assessment that would include whether a patient needs an accommodation. If the patient needs an accommodation the nurse needs to refer promptly to a provider so the patient is immediately seen or the nurse should promptly obtain an order for the accommodation. Patients should not wait up to a day to have an accommodations ordered and provided. It should be clear if the patient was provided an accommodation device and when it was provided.

[70] By Dr. Abebe done for the prior report.

Record reviews demonstrate that items 1 and 6 above continue to be a barrier to compliance on this provision. When auditing, DPSCS must ensure that the accommodation is timely which means that the accommodation needs to be made when the patient enters the jail. This means that nurses performing the IMMS and providers performing the health assessment identify and timely address disability and accommodation needs. This is not occurring. The audit should consider the timeliness of receipt of an accommodation.

The current ADA rounds report contains a picture of the inmate with any durable equipment supplied to them. I would date/time stamp the photo so that the timeliness of provision of the supply is recorded because timeliness of receipt of an accommodation is required.

The issue of whether the patient is in appropriate housing is not addressed in the DPSCS audit. The new electronic record included an upgraded interface with OCMS and NextGen which should enable DPSCS to identify who is in a low bunk, in the infirmary, or on a unit where continuous-positive-airway- pressure (CPAP) can be used. ITCD should be able to obtain data for who is in a low bunks and the for where ADA patients are housed. ITCD should be able to compare orders for housing with actual housing locations. This was discussed in section 20b. A new recommendation to do this is given in 20b.

The sally port housing is still unacceptable housing for many patients with ADA needs including those with paraplegia, significant mobility disorders, neurological impairments, colostomies, indwelling urinary catheters, neurogenic bladder or bowel, etc. Because some patients remain in the sally port for longer than several hours, procedures should clearly define how an ADA patient is housed whose intake processing will take longer than a few hours. I recommend that patients with these significant issues not remain in the sally port longer than 8 hours total. This has not yet been done. This should be defined in the official procedure.

DPSCS has improved facilities in the infirmary. Two of the showers are now ADA accessible and are wheelchair acceptable. Grab bars have been installed. Water in one of the showers was not warm. Quick heat water-heaters are being used and I was told that after a few inmates shower, it takes a while for the water to re-heat. Work is not yet complete on these renovations. The remaining shower on the infirmary unit should be made ADA acceptable. Multiple beds have been replaced. Patients appeared to have appropriate bedding. I did not inspect equipment but in the last report recommended the following equipment.

1. Walkers
2. Wheelchair with cushions as needed
3. Crutches
4. Canes
5. Bed alarms
6. Shower seats and bathroom wheelchair
7. Call systems
8. Hoyer lift
9. Wheelchair transfer slide board
10. Trapeze or other device to assist in transfer movements for person in bed

11. Appropriate bed (hospital adjustable or air mattress)[71]

In 21 record reviews, I identified 34 deficiencies with respect to provision 21a. These can be reviewed in the record reviews.

Two examples are provided from record reviews. One example is a 65 year old[72] who on IMMS screening was identified with hypertension and chronic pain with unspecified pain medication and amlodipine identified as his medications. The nurse identified no deformities and no difficulty walking. On provider intake assessment, the patient told the provider he had migraines, hypertension, osteoarthritis and bilateral hip replacements with arthroplasty due to an old gunshot wound. On the examination section of the note, the provider documented that the patient had fallen the day before and had a skin abrasion. The only musculoskeletal examination was that he had a steady gait and swollen shin with normal appearing extremities. Given a fall in a 65 year old a better physical examination was indicated. About six weeks later, the patient complained having trouble remembering things from one moment to the next. When a provider saw the patient a couple days later, the patient did not have a cognitive assessment. Despite being seen for memory loss the only neurologic examination was "alert and oriented x 3. Grossly normal intellect … oriented to person, place and time". This person was described as a poor historian and now described a memory deficiency but was not evaluated for a cognitive disability that may have warranted protective housing. For this episode a cane and low bunk were ordered which the patient was documented as given on 12/8/21 but on 12/17/21 the patient placed a health request asking for his cane. This person never did get a cognitive assessment and did not receive a cane timely.

In another record review[73] on the IMMS, on 2/21/23, a nurse documented only hypertension and heroin abuse as problems. On the health assessment, however, a provider documented prior stroke and head injury requiring surgery which were not identified in the IMMS. I interviewed this patient on the unit and he had an obvious cognitive problem that was unrecognized. On 3/16/23 a provider evaluated the patient who said he had fallen recently but didn't know where he fell. He had prior frostbite. The provider documented lateralizing drift to the left when he walked unassisted. The note documented he spoke slowly and was sometimes forgetful. He did not have a cognitive assessment. He was placed on the infirmary. The provider's initial neurologic examination was auto-filled and documented "normal memory". This person was on the ADA log because he needed a cane but his cognitive issue was significantly more important as it impaired his ability to function safely in general population. The need for the cane was not identified for about a month. DPSCS has narrowed the definition of disability to those requiring an accommodation for mobility, but need to expand it to include other disabilities.

Six recommendations were given in the last report. Recommendation 1 has been removed and replaced by recommendation 1 in section 20b above. Recommendation 2 was addressed in a DPSCS ADA record review report over a year ago but should be periodically repeated. Recommendation 3 included improvement of the IMMS screen to improve capture of disability

[71] Plaintiffs' counsel asks that ankle foot orthotics be kept onsite. These devices typically need to be fitted to the individual and therefore would not be kept in stock. Plaintiffs' counsel also asks why catheter tubes, drainage bags and colostomy bags are not included. This was an equipment list not a supply list.
[72] Patient 3
[73] Patient 19

needs. This is in progress. Screenshots were provided and I have given suggestions to improve the screens. This can be re-evaluated after implementation of the new form. Recommendation 4 was to perform a root cause analysis of the timeliness of provision of appropriate ADA housing and supplies. That analysis was not done. An ADA report[74] was done about a year ago which gave details on the complex paper process used to identify and address ADA issues. To my knowledge, no corrective actions were completed based on that report. This report can be used as the starting point for a root cause analysis. Recommendations 5 and 6 were not completed.

In summary, scores do not yet warrant compliance. The policy and procedure needs revision. Intake nurse screenings and provider initial assessments need to screen for, identify, and order disability needs. Accommodations need to be promptly identified and ordered. Patients with many disabilities should not be housed in the sally port. Movement to the infirmary from the sally port for those needing infirmary housing should not be delayed. Nursing assessments need to be done in intake. Provider physical examinations need to occur for persons with disability to identify their needs. Though DPSCS asserts compliance, audit scores are not yet substantially compliant but are improved. The infirmary physical structure has been improved. No effort has been made to take corrective action on DPSCS's record review audit from last year. While some persons with ADA concerns are tracked and appropriately managed, others are not tracked or managed appropriately. Considerable work remains with respect to tracking and providing appropriate supplies and equipment. This provision remains in partial compliance but progress has been made.

Recommendations:

1. Record reviews being done for provision 18 should include a group of persons on the ADA unit who need supplies. Those record reviews should attempt to identify why the intake assessments are not identifying ADA needs and where there are opportunities for improvement. Results of these reviews should result in revisiting the intake procedure and in development of a standardized procedure to ensure ADA patients receive appropriate intake assessment and receive appropriate orders for supplies.
2. For the new electronic record, improve the intake screening form and provider screens to include identification of durable medical equipment and ordering specialized medical housing. This should include specialized medical housing for CPAP, conditions requiring low bunk placement, protective housing for dementia, etc.
3. I have concerns regarding timeliness of provision of durable medical equipment (DME) and appropriate housing of ADA patients. A root cause analysis of these items should be performed and corrective action taken. This should include review of policy and procedure, that intake evaluation identifies disabilities requiring housing or supplies and equipment and that these are timely ordered and provided, and that persons are appropriately housed after orders.
4. The DPSCS audit should include a monthly environmental inspection of ADA facilities. This would be an environmental rounds checklist. The auditors should include the ADA nurse, ADA coordinator and a custody environmental person. For the infirmary the checklist would include all equipment items on the list for the infirmary cited above. For showers and toilets of all ADA toilets and showers the checklist should verify for each

[74] By Dr. Abebe sent to me 9/15/21

named location that the ADA toilets and showers are functional, clean, do not have missing tiles or surfaces that promote slipping, have appropriate grab bars, have functional and operable shower chairs, and showers that are functional and release appropriately heated water. This can be on a checklist format and should be performed quarterly and delivered to the quality improvement committee and used by auditors to verify compliance with this provision.

5. Revise policy and procedure to ensure current practices are consistent with requirements of the Settlement Agreement. This revised procedures should also include revisions based on findings of the process analysis done on the ADA population from the last report. New procedures must ensure that the ADA population receives their ADA accommodations beginning in the sally port after the need is identified. This needs to be codified in the revised procedure.

Settlement Agreement Statement: 21.b. *A staff member with appropriate training shall be designated to address concerns of plaintiffs with disabilities regarding accommodations for their disabilities and to assist in the resolution of any security issues that may threaten provision of necessary accommodations.*

Compliance Rating: Partial Compliance

Findings:

DPSCS must show:

- That staff is assigned to address concerns of individuals with disabilities regarding their necessary accommodations.
- That when a problem with security arises, the staff assigned to address concerns assists in the resolution of security issues that threaten provision of the accommodation.

This provision is related to provision 20b in that the staff required by this provision need to assist in resolutions of issues discussed in 20b. DPSCS asserts compliance with this provision but provided no data in the YesCare report to verify its compliance. The YesCare report states that multidisciplinary rounds with custody and medical staff include physical rounds on the ADA units. These rounds are weekly and now include the infirmary. An MTC Director of Nursing and ADA officer conduct rounds. The same process used at BCBIC to follow ADA patients is now used to follow infirmary patients.

The current ADA log used for ADA rounds on 3/8/23 has 31 persons but does not include those in low bunks, on the infirmary nor anyone on CPAP. The ADA report, based on the ADA log, continues to report weekly pictures of all inmates on the ADA log showing their durable medical equipment along with any complaints of the inmate.

The ADA log is a useful tool to monitor those who require both housing and medical equipment or supplies but it does not consider all those patients who require specialized housing to include low bunks, housing required to use CPAP, housing for elderly with dementia or memory issues, etc. Because of the implementation of the upgrade of the electronic record, it is now time to track

ADA patients electronically instead of on paper logs that are subject to error and difficult to maintain. Recommendation 1 in section 20b describes a query that now should be able to be performed. This query should inform the ADA nurse and ADA coordinator of what is going on with ADA patients.

The purpose of the ADA nurse and ADA custody person is specifically to address concerns of inmates with disabilities regarding their accommodations and to assist in resolution of any security issues that may threaten their obtaining the necessary accommodation. The policy governing this is required in provision 20b. A current finding of a problem with the ADA nurse and ADA custody representative lack of intervention is provided below.

This patient[75] placed a health request for a bottom bunk stating he had leg damage. The bottom bunk was documented as ordered on 2/8/22. A bottom bunk had also been ordered in late 2021 and it was unclear why the patient did not still have this permit. I was told that the patient may have still had a bottom bunk permit but due to patients that may have more urgent bottom bunk needs such as uncontrolled seizures or withdrawal protocol, patients may get moved off of their bottom bunk by custody. On 3/14/22 the patient placed a sick call slip documenting he needed a bottom bunk slip and "verification" for his cane, saying he would sue if he didn't get his bottom bunk or cane. It wasn't clear if the patient didn't actually have a cane or bottom bunk or whether he was worried he would lose the privilege. But it appeared that neither order had been completed. A provider subsequently saw the patient for the health request. The provider described the patient as walking without a cane and requested a bottom bunk because he was moved and when moved was assigned to a top bunk and officers took his cane away. The provider said that the cane was seen in the officer's station and the provider wrote that the officer on the shift said he would give the cane to the patient when needed for ambulation. The cane was apparently taken for safety reasons but the basis for taking the cane was unclear. The only examination of the legs was "extremities are normal". The provider documented that the bottom bunk was re-ordered but why did the bottom bunk need to be re-ordered? The provider told the patient to request the cane when needed for ambulation. This is inappropriate. The patient should have been housed on a unit where canes are permitted. I was told that canes are permitted on all units but if a patient uses a DME in aggressive manner security takes the cane from them. The ADA nurse and custody ADA coordinator should have been involved as required by the Settlement Agreement. As discussed in provision 20b above, DPSCS policy, procedure, and directives require that medical decisions regarding implements such as durable medical equipment will not be overturned by custody. This should be expanded to include housing assignments and supplies, but more importantly, needs to include procedure for how this is resolved when custody removes durable medical or a housing assignment from an inmate. A recommendation has been added for this to provision 20b.

Another patient[76] was 65 years old, had prior bilateral hip replacements, a prior fall, and pain from osteoarthritis. The patient had a hard time walking due to pain and arthritis. On 5/16/22 he placed a health request that he had pain that made it hard to get up and down or walk long distances and he couldn't stand for extended periods of time. The day after the health request was placed the ADA nurse evaluated the patient and wrote, "Detainee has h/o chronic pain to bilateral hips and uses a cane to assist with ambulation. He is assigned and seen on bottom bunk and is able to

[75] Patient 15
[76] Patient 3

perform ADLS without assistance. He denied having any medical concerns during this visit". The fact that the patient placed a health request the day before the nurse stated that he had no medical concerns speaks to ineffective communication or perhaps the inmate not understanding the role of the ADA nurse.

Another patient[77] was evaluated on 2/16/23 by an ADA nurse. The nurse wrote, "Detainee has an H/O femoral fracture s/p ORIF [open reduction internal fixation]. He uses a walker to aid ambulation. The detainee is assigned a bottom bunk bed and has no medical concerns at this time". This note failed to acknowledge the actual status of the patient who has been in constant pain, had a non-union of his fracture, was late for an orthopedic appointment, and had considerable dental issues which did not appear to be addressed. This also was ineffective communication.

In summary, ADA patients on the infirmary do not appear to be followed by the ADA nurse. There is an ADA nurse and a custody ADA employee. Rounds are done but rounds do not include review of persons housed in general population on low bunks or on CPAP. This can be addressed by inspection of a report generated by ITCD as recommended in recommendation 1 in section 20b. The ADA nurse does write progress notes in the medical record to document her visits. However, communication needs to be more effective with respect to understanding the concerns of ADA patients. I suggest in section 24 to improve the Combined Chart Summary that includes all sick call requests presented chronologically. The ADA nurse should review these when seeing patients to evaluate any complaints the patient may recently have had.

The remaining issue is that the ADA nurse is to address concerns and assist in resolution of concerns regarding persons with disabilities. Based on record reviews, improvement is needed in these areas. Of concern is that based on the record review, there is a practice of custody making ad hoc decisions to remove low bunk privileges or take canes based on individual officer decisions. Custody should develop post orders that anytime an inmate with a low bunk order is not placed in a low bunk or anytime an officer takes a cane from an inmate for any length of time, it should be reported up the custody chain. I would recommend that the ADA nurse receive a copy, the day of receipt, of any health request regarding a cane or low bunk and any custody reports of officers removing a cane or inability to house a patient on a low bunk. The ADA nurse and custody ADA representative should meet with the patient and assist in resolution of the issue. The ADA nurse should document the resolution in the medical record and custody should document in a custody ADA report.

Because low bunks and canes are orders, I have suggested that the expiration dates of low bunk orders and canes be placed in the Combined Chart Summary. A list of soon to expire orders for these (two weeks in advance) should be provided to the ADA nurse and custody ADA representative so they can interview the patient to assess whether such expiration is appropriate. The ADA nurse should alert an appropriate provider of the expiration. This information also

[77] Patient 16

should be reported in the medical record or custody ADA log. It would also be useful for the ADA nurse to review the medical record before patient visits to review any health requests of the patient.

Two recommendations were given in the last report. Neither were addressed. Two additional recommendations were added based on findings in this report.

Recommendations:

1. The ADA nurse and ADA coordinator must follow ADA patients on the infirmary.
2. DPSCS should define how the ADA log is configured as it does not appear to represent all persons who have disabilities.
3. The ADA nurse should receive a copy, the day of receipt, of any health request regarding a cane or low bunk or other accommodation. The ADA nurse and custody ADA representative should meet with the patient and assist in resolution of the issue. The ADA nurse should document the resolution in the medical record and custody should document in a custody ADA report.
4. The ADA nurse and custody ADA representative should receive from ITCD a weekly report of all ADA orders for all expiring ADA orders including low bunks, canes, crutches or other aides to disability. The ADA nurse should interview the patient to assess whether such expiration is appropriate and contact the physician who is responsible for the patient to ensure continuity of the ADA order. This information also should be reported in the medical record by the ADA nurse.

Settlement Agreement Statement: 21.c. *Plaintiffs with disabilities shall be provided with access to specialized medical services, such as dentists, mental health treatment, and offsite medical specialist treatment, on the same basis as plaintiffs without disabilities.*

Compliance Rating: Partial Compliance

Findings: DPSCS asserts compliance with this provision. This provision requires DPSCS to verify the following:

1. That patients with disabilities have access to medical, dental, mental health, and offsite specialty services as shown by show rates at appointment schedules and have access to specialty care as necessary.
2. That onsite services have rooms that are ADA appropriate with respect to being able to enter and navigate the treatment room in a wheelchair and that examination tables are available to accommodate the person with disabilities.

The YesCare report provides data that there is documentation of an encounter for clinic appointments 90% of the time. Rescheduled appointments occurred only 42% of the time. There were few rescheduled appointments. The numbers of appointments were not provided. The data

to support this audit were not provided. This audit only audited scheduled appointments but patients with a problem for which they should be referred for care is not considered.[78]

On record reviews there are still problems. Seven deficiencies were noted in the 21 record reviews. One patient[79] had a prior gunshot wound to his leg with residual nerve damage. A subsequent evaluation documented the patient as "tabetic"[80] and falling to the right when walking. Later, (1/21/22) a provider ordered a cane for the patient. On 2/22/22 the patient requested physical therapy. On 4/1/22 a provider note documented "he uses his cane to keep his balance". The patient told the doctor he had requested physical therapy but it was not approved. No physical examination was done; nor did the provider evaluate whether physical therapy was necessary. The provider advised the patient to do physical therapy by himself. This is inadequate access.

Another patient[81] sustained a femur fracture and was hospitalized and came to the jail from the hospital. The patient went for an orthopedic appointment on 4/11/22 and the orthopedic physician recommended physical therapy three times a week for eight weeks. On return to the facility, the physical therapy was not ordered. The patient's follow up appointment with orthopedic surgery was not documented as referred until, on 6/10/22, a physician apparently noticed the patient had not yet been referred. This referral was not present in the YesCare UM Consultation Log and was not carried out. On 5/27/22, the patient placed a health request complaining of leg pain. When a provider saw the patient on 5/30/22, the patient asked for physical therapy, which was to have been ordered on 4/11/22. The provider ordered the physical therapy on 5/30/22 which was approved by YesCare on 6/14/22, two weeks later. Physical therapy started on 6/21/22 about two and a half months after recommended. The last therapy session was 9/30/22 when the therapist recommended that the patient return to orthopedic surgery for follow up, which had not yet been scheduled since 4/11/22, more than five months ago. A provider referred the patient to orthopedic surgery on 10/5/22 but it wasn't approved until 10/28/22, three weeks later. The patient eventually apparently went to orthopedic surgery but it is unclear when. The log documents that the patient went to orthopedic clinic on 11/7/22 but there was no documentation on this date in the medical record of an appointment. There was no consultation report. A subsequent provider visit documented that the patient went for his orthopedic appointment on 11/8/22. This patient alone ultimately had six episodes for which access was not present or was considerably delayed.[82]

Other examples of access problems are present in the record reviews.

---

[78] Plaintiffs' counsel ask for a finding of noncompliance because DPSCS failed to provide data and failed to audit the appropriate universe of cases. The partial compliance was mostly based on record reviews which showed problems but warranted partial compliance.

[79] Patient 15

[80] Tabetic is defined as unsteady, uncoordinated and ataxic gait.

[81] Patient 16

[82] A recommendation for orthopedic follow up was not scheduled. A referral to physical therapy was delayed for six weeks. Patient had complaints of dental pain but was not referred to a dentist. A breast ultrasound ordered 4/27/22 but referral not addressed; reordered 5/30/22; referral denied with recommendation to order mammogram; mammogram done 7/21/22 almost 3 months later. On 11/7/22, an orthopedic doctor recommended a CT scan with follow up as soon as possible. The CT scan was ordered as an "urgent" test but wasn't done until 12/14/22 about 5 weeks later. The patient was referred for orthopedic follow up on 12/19/22 and the patient wasn't seen by orthopedic surgery until 2/20/23 about 3 months after an "as soon as possible" follow up was requested.

In summary, DPSCS scores are good with respect to patients who are scheduled showing up for their appointments albeit rescheduling scores being low on a small number. Record reviews, however, show lack of access to specialty services. Access is not just showing up at an appointment. Patients must have ability to see a provider or consultant necessary for their needs. This is not audited by DPSCS.

Two reports ago, I asked DPSCS to report scheduled appointments for this provision to be reported in the same manner as with 20a. This was not done as DPSCS remains in the process of implementing a standardized scheduling system using the EPHR. Two recommendations were given in the prior report. Neither recommendation was addressed. Also, the data used to write the DPSCS report was not provided in the report.

Recommendations:

1. Correct access to specialty care for disabled individuals.
2. Present scheduling data for ADA patients in the same format as requested in provision 20a.
3. Provide data used in the YesCare audit in the YesCare semi-annual report.

Settlement Agreement Statement: 21.d. *The Commissioner shall promulgate and implement policy and procedure to use a vehicle with adaptations to make it suitable for the safe transportation of persons with mobility-related disabilities to transport plaintiffs with such disabilities, unless such vehicle is not available in an emergency situation.*

Compliance Rating: Substantial Compliance

Findings: I did not review the vehicle on this visit. There has been no change to this provision and DPSCS remains in substantial compliance.

Recommendations:

1. None

SPECIALTY CARE/CONSULTATION

Specialty Care Compliance: Noncompliance

Settlement Agreement Statement: 22.a. *The Commissioner shall promulgate and implement policy and procedure to ensure timely review of requests for routine, urgent and emergency specialty care.*

Compliance Rating: Partial Compliance

Findings:

This Settlement Agreement provision requires DPSCS to verify:

- That it has a policy to ensure that all referrals are timely reviewed for routine, urgent and specialty care.
- That the policy and procedure are implemented.

As discussed in the last report, DPSCS and the vendor's policies are not in synch. The current practice does not follow DPSCS policy. I have recommended that the DPSCS policy be revised but this has not been done. The vendor policy should be consistent with Settlement Agreement requirements and DPSCS policy. Current practice is not following DPSCS policy.

There have been some improvements. Decisions are now documented in the medical record by the vendor department. This was verified in record reviews. The decision is appended to the consultation request and appears on the date of the consultation which is satisfactory. The author of the decision is anonymous but they should document their name. On one decision[83], an alternative treatment plan was given but it was not clear what referral the plan was for. These decisions should include the name of the author and the precise referral so the decision can be associated with a referral. The specific referral should be clear to the reader of the electronic record. This change in practice addresses recommendation 1 in the previous report which is removed. A recommendation that the decision maker sign their name and that any approvals or denials clearly refer to a specific referral will remain.

Three recommendations were given related to this item in the prior report. Recommendation one was mostly addressed and was modified. Recommendations 2 and 3 were not addressed. I modified and abbreviated the recommendation to revise current DPSCS policy because it is out of date. The current DPSCS policy[84] describes practices that DPSCS used over a decade ago when there was a different vendor with different practices. The policy needs to be revised. Items II.P and II.Q in the current policy should be revised as recommended in section 22d below. Item II.R in the policy should be revised. It states that anyone with a pending consultation can't be transferred. This is not possible because BCBIC is a jail and not a prison; when a person is convicted, they must be transferred to a prison and probably can't be held pending an appointment. The timelines in the DPSCS policy are consistent with the Settlement Agreement but could be more clearly stated. DPSCS and vendor policy (if it is used) should be consistent with all four items of provision 22 of the Settlement Agreement. Recommendation 3 was not addressed and still needs to be acted on.

The YesCare report has three audit questions pertinent to implementation of the DPSCS policy.

1. Consultation form was completed in its entirety 81%.
2. Referral processed in a timely manner 92%.
3. Evidence in the UM log that offsite appointment was scheduled timely after the authorization number was provided 100%.

These questions do not adequately audit whether DPSCS policy on consultations is implemented.

[83] Patient 1, UM Review dated 11/9/22 at 1:11 pm
[84] DPSCS Office of Clinical Services/Inmate Health, Chapter 5, Consultations

DPSCS has made one improvement. The vendor physician now documents their review in the medical record but it does not appear to be consistently done. Because there are many patients who are referred but never appear on the log,[85] it appears that there are a group of patients who never have a decision because their referral is not processed. This must be corrected.

I found 11 deficiencies in record reviews referable to this provision. These can be reviewed in the medical records attachment.

This provision remains partially compliant because the DPSCS policy is outdated and current practice is not consistent with DPSCS policy. The procedures of the policy need to be revised to be contemporary with existing expected practice. After a policy is written the implementation of that policy will need to be demonstrated.[86]

Recommendations:

1. The reviewer should document their name, continue to include the date of their review, and refer to the specific consultation they are reviewing.
2. DPSCS should review and revise their consultation policy.
3. Record reviews show patients are referred but appear not to be reviewed by the vendor UM physician indicating a problem with the consultation ordering process. It was not possible on my record reviews to reasonably track a referral from the physician initial referral through to a completed consultation that includes all steps required in DPSCS policy. A root cause of this should be performed and a workflow analysis should be done in conjunction with implementation of the electronic medical record.

Settlement Agreement Statement: 22.b. *Such policy and procedure shall provide that plaintiffs are referred to specialists as medically necessary and that the process for review and approval of specialty consultations does not take more than 48 hours for urgent care and five business days for routine care.*

Compliance Rating: Noncompliance

Findings: This Settlement Agreement provision requires DPSCS to verify:

- That patients are referred to specialists as medically necessary.
- That the process for review and approval of specialty consultation does not take more than 48 hours for urgent care and five business days for routine care.

DPSCS has not addressed the fundamental problem described in the last report. DPSCS's eligible audit population includes only ***completed consultations*** and does not sample persons in need of consultation who are not referred or persons who are referred but whose consultations do not even

[85] See section 22d below for further explanation.
[86] Plaintiffs' counsel argue for a noncompliance rating because neither policy nor practice was shown to be appropriate. Credit was given because of the improvement in documentation of reviews in the medical record. The number of reviews completed within appropriate timelines also warranted a partial compliance. As stated in 22b, the number of timely reviews, in my own audit was 70% which also warranted a partial compliance.

result in a review. DPSCS reports that 100% of consultations are scheduled ***after an authorization number was provided to the site.*** A DPSCS audit of ADA patients in 2021 showed that only 13 of 40 referrals actually resulted in a completed consultation. A large number of consultations (15) were never reviewed by the vendor. This may be a problem with a defective medical record consulting template which appears to not result in a reviewable referral. Providers I spoke with confirm that sometimes, referrals are sent through the electronic record but they can be lost or not properly categorized as being received and sent for UM review. This results in attempts to re-order the consultation later or in a lost referral. This appears to be a medical record process problem that must be corrected.

The YesCare audit reported the following applicable to this provision.

- The referral was processed in a timely manner (routine referral 12 business days, urgent referral 5 business days, emergent referral same day). Average score 81%

This question is not consistent with requirements of the Settlement Agreement which requires review and approval of urgent referrals to be completed within 48 hours and routine referrals to be completed in five days. The YesCare audit therefore does not provide sufficient data to verify compliance.

In record reviews of 21 patients, I found 32 deficiencies demonstrating continued poor performance. Several patients needed referrals but the referrals were not timely or did not occur. Some patients needing referral were not referred. Some patients needed referral and were referred but there was no evidence of the referral being scheduled or evaluated by the team. Numerous examples are provided in record reviews. I did examine ten consecutive patients on the log; seven (70%) had timely review. One example in the record reviews, discussed below, showed numerous examples related to lack of access to specialty care. More examples can be evaluated in the record review attachment.

This patient[87] was re-incarcerated 2/16/21. He was identified as having bilateral leg amputations. The IMMS documented "altered mental status" and the patient was sent to the hospital for this purpose. At the hospital a CT scan of his brain showed possible old stroke, and area of encephalomalacia[88], and changes consistent with chronic ischemic changes. Clinical correlation was advised. The intake health assessment was performed after the hospitalization but no neurocognitive testing or neurologic examination was done to determine if the patient had a cognitive disorder and there was no follow up of the abnormal CT scan. The patient had known severe mental illness and it was uncertain whether the patient's brain changes affected his presentation with respect to his mental illness. On 7/14/21 the patient was referred to infectious disease for treatment of his hepatitis C. There was no evidence that management addressed this referral.

The patient placed health requests on 5/1/22 and 5/2/22 asking for help with his prosthetic legs. The record documented he refused to be seen for these requests. On 5/5/22 the ADA nurse saw

[87] Patient 23; this patient's review was not duplicated in the record reviews.
[88] Encephalomalacia is softening of the brain due to old trauma, bleeding, or inflammation.

the patient and documented that the "Detainee has h/o chronic pain to right lower leg S/P ORIF [open reduction internal fixation] and ambulates with a cane. Assigned and seen on bottom bunk is able to independently perform ADLS. Denies any medical concerns at this time". This patient had amputations with two prosthetic legs and did not have ORIF. This person had just placed a health request. The ADA nurse was unaware of the health requests and communication with the patient appeared ineffective with respect to addressing his ADA concerns. On 5/12/22 the patient again placed a request asking for help with his prosthetic leg. A provider saw the patient the same day and documented that the patient requested to know the status of his prosthetic because they didn't fit him. The only examination was to document that the patient had below knee amputations. The only plan of care was "patient reassured". This patient should have had an evaluation of his prosthetic device and been referred to an orthotist to evaluate his prostheses. About six weeks later, the ADA nurse documented that the patient was using a wheelchair and documented, "He denied having any concerns during this visit". The following day the patient was issued a wheelchair. This was ineffective communication addressing the concerns of the patient.

On 8/23/22 the patient placed another request again about his prostheses. The provider seeing the patient documented that the patient was referred by the warden about his prostheses. The provider referred the patient to an orthotist. The referral was initially reviewed by the provider on 9/6/22, about two weeks later (should have been five days). The request was denied with the statement "as IM states the prosthetic does not fit due to weight gain, the next step would be to verify such by conducting an objective examination with the prosthetic on". On 9/6/22 a provider did check the prosthesis fitting an apparently communicated back to management who approved a visit to an orthotist. Approval was finally given on 9/16/22 (again not timely review).

On 10/10/22 a provider referred the patient to an orthopedic physician because the patient told the provider that he was told an orthopedic consultation was necessary to evaluate his prosthesis so the provider referred to the orthopedic surgeon. This referral was denied seven days later (again not a timely review) with the statement "Medical necessity for orthopedic consult is not demonstrated at this time. Consider having a primary care provider evaluate ambulation needs". This referral was not in the specialty log.

On 10/11/22 the specialty log documented that the patient went to the orthotist. This was confirmed on a subsequent provider note but the report was not in the record. Providers subsequently documented that a new prosthesis was recommended. There was no documentation in the record, except for the provider notes, that the patient went to the orthotist.

On 10/12/22, the patient was evaluated by an ophthalmologist. This visit was not in the specialty log but there was a report. This patient had a macular hole and it was recommended that he be referred to UMMS retinal clinic. Macular holes may need treatment due to risk of visual loss. The report was not reviewed and the patient was lost to follow up for this problem. About four months later, on 2/10/23 a provider must have noticed the ophthalmology report and referred the patient to the retinal clinic. The consultation was approved but as of 4/2/23, there was no evidence that the patient was sent to the retinal clinic. This was at least a six month delay with uncertain effect on his vision.

On 10/13/22, a provider referred the patient to the orthotist but the review denied the referral on 10/17/22. This referral was not present on the specialty log but the Settlement Agreement requires that all referrals are to be maintained on the log. The reviewer stated, "Based on the information provided, medical necessity has not been demonstrated at this time. Existing prosthetics are noted to not fit due to weight gain. Hanger did not evaluate the patient's existing prosthetics. Consider an objective examination with the prosthetic on. It may be appropriate to trial weight loss followed by reassessment of prosthetic fit and function". The follow up plan of care was to have the patient lose weight. In my opinion, this is inappropriate. The primary care doctor is not qualified to assess the fit of a prosthesis.

On 11/18/22, a provider documented in the progress note referral for a colonoscopy because of age (51) and anemia[89] but there was no review and the referral was not present on the referral log, indicating perhaps a problem with processing referrals. This was an appropriate referral that was lost to follow up possibly due to a defective referral ordering system or lack of training.

On 11/23/22, the patient was admitted to the infirmary due to refusing insulin and being non-communicative. The provider admitting the patient documented referring the patient to an orthotist for a new prosthesis. There was no review and the referral was not present on the specialty log. It was either ignored or there was a problem with transmission of the referral.

On 11/30/22 a provider documented that the plan for the prosthesis was to have the patient lose weight. On 12/13/22, the patient was discharged from the infirmary.

On 1/17/23 a provider documented needing the report from the apparent 10/11/22 orthotist consultation. The provider wrote, "When is the follow up? What is plan for fitting? Schedulers have been emailed". This exemplifies an uninformed referral process. The providers do not appear to know whether the patient has a pending consultation.

On 1/25/23 the patient asked about his prostheses and the provider told the patient that he was waiting for the orthotist report.

As of 4/3/23, there was no evidence that the 10/11/22 orthotist consultation report was ever obtained, no apparent plan to fix, refit or replace the prosthetics, no scheduled date for the retinal clinic, and the colonoscopy has not been done.

The three recommendations from the last report were not addressed. This provision is still noncompliant.

Recommendations:

[89] Hemoglobin was 10.8 on 8/25/22, was 12.9 on 10/5/22. A hemoglobin of 12.9 is normal but the blood test was not repeated and a stool for guaiac was not performed. A follow up emergency room visit on 1/24/23 again documented mild anemia. In any case, any person over 45 with anemia should have colonoscopy.

1. Incorporate quality record review information based on reviews done for provision 18 to verify quality of care for this provision. These reviews should be performed by the non-YesCare physicians[90].
2. DPSCS should consider allowing the facility medical director to approve decisions due to poor utilization review done by the vendor.
3. Perform a root cause analysis on the ordering of specialty care to focus on the NextGen upgrade to ensure that a simplified and efficient process is in place that reduces referrals that never occur.

Settlement Agreement Statement: 22.c. *The Commissioner shall promulgate and implement policy and procedure to maintain a log documenting the date a Clinician requests approval of a specialist referral; the date utilization management takes action on the request; the outcome of the request; and whether the referral is to a specialist for the purpose of treatment or for the purpose of evaluation only. Clinicians shall be given training regarding the documentation necessary to support a specialty request.*

Compliance Rating: Noncompliance

Findings: Based on the Settlement Agreement the following items are required:

<u>To Be Documented in a Log</u>

1. Date of referral;
2. Date of utilization action;
3. Outcome of utilization action; and
4. Purpose of referral

DPSCS has not asserted compliance for this item. Upon request, DPSCS did provide a log that is required for this provision. The log is inaccurate. The log does not include all referrals and only includes completed and approved consultations. As in the patient[91] example in the section on provision 22b, there were five referrals for specialty care over a four month period. One patient apparently went but the report wasn't available and there was no documentation the day of the visit that the patient went for a specialty referral. One referral was denied. Three referrals were not addressed by the utilization provider, one of which may have been the result of a mistake in filling out the consultation. *Four of the five were not in the log*. Only the consultation that apparently occurred was documented in the log. There were no denials on the log although, for certain, there is a utilization decision denying two and possibly three of the consultations. One consult that was eventually approved was initially denied, but that denial, as well, is not present on the log. The log is unreliable. All referrals must be placed on the log and all denials must be recorded.

[90] Plaintiffs' counsel ask who non-YesCare physicians are. These would be physicians who are independent physicians.
[91] Patient 23

None of the recommendations in the last report were addressed. DPSCS provided no data or information to verify its compliance with this provision and no questions on the audit refer to this provision. This provision remains noncompliant.

Recommendation four was modified to recommend revision of the policy and procedure on consultations because it is dated and practices have changed with the upgraded medical record.

Recommendations:

1. Denials of care need to be included on the log. All referrals should be on the log with their disposition.
2. Make modifications to the DPSCS tracking log as recommended.
3. Provide the specialty care log as an appendix to the next YesCare report or send as a separate excel file.
4. Revise and implement DPSCS policy on specialty care.

Settlement Agreement Statement: 22.d. *The Commissioner shall promulgate and implement policy and procedure to ensure that, if applicable, each plaintiff's medical record contains documentation of requests for outside specialty care, including the date of the request, the date and nature of the response, the date any consultation is scheduled, the date of any consultation, and appropriate information, if any, regarding follow-up care.*

Compliance Rating: Noncompliance

Findings: DPSCS does not assert compliance for this item.

The Settlement Agreement specifically calls out that the following items are to be documented in the medical record:

1. Provider request for referral- this can be evidenced by a dated progress note describing the referral or a consultation referral in the electronic medical record;
2. The date and nature of the utilization response;
3. Date the consultation was scheduled;
4. Date the service was provided; and
5. Information appropriate for follow up.

Though required by the Settlement Agreement, items 3 and 4 are not provided in the medical record and item 5 is sometimes provided but often not provide. In section 18f I discuss the Combined Chart Summary. This summary is intended to provide information necessary to inform the plan of care (provision 18). The Combined Chart Summary has multiple links one of which is a consultation link. This link currently only provides information on authorized consultations. I am recommending that the Combined Chart Summary provide the following information:

1. All referrals with the date of referral;
2. The utilization decision (approved, denied (ATP)) with the date;
3. A link to the scanned copy of the alternative treatment plan;
4. The scheduled appointment date;

5. The date the appointment was completed;
6. A link to the scanned copy of the consultation report.

This would satisfy requirements of 22d and would significantly improve access of providers to important information that currently they have to extensively search for and sometimes cannot locate.

In addition to these required items, DPSCS policy and procedure requires the following additional items to be documented in the medical record.

6. The medical indication for the consultation.
7. The current DPSCS policy requires that if the Medical Director of BCBIC disagrees with the referral by a provider, the Medical Director is to document an alternative plan in the medical record. Because the utilization physician and not the medical director make utilization decisions, the utilization physician needs to document their alternative treatment plan in the medical record.
8. The current DPSCS policy requires that the Regional Medical Director is to document the outcome of the collegial review in the medical record. However, this directive existed when the medical director and regional medical director made utilization decisions. Because a utilization physician makes utilization decisions, that physician should document their utilization decision in the medical record.
9. The reason for any delay is to be documented in the medical record.
10. Missed appointments are to be documented in the medical record by the contractor.
11. All cancelled or denied consultations are to be documented by a physician in the medical record including an explanation as to why the consultation is no longer medically indicated. The Monitor strongly recommends that the vendor utilization physician make this documentation because the utilization physician is the one who made the denial. The referring physician should not be required to document why the utilization physician denies the referral.
12. A physician is to review the consultation report with the patient and document that discussion in the medical record.

In the section on 22a, I recommended that the DPSCS policy be revised. Items 6, 9, 10, 11, and 12 should remain in any new policy. Items 7 and 8 are optional and depend on DPSCS's opinion of the utilization process.

Only one item (1 above) and part of a second item (12 above) are monitored in the DPSCS audit.

The following three questions in the YesCare audit pertinent to this provision with their scores are as follows.

1. Consultation form was completed in its entirety 81%.
2. Did provider review the consultation report and provider follow up care and document in the EPHR within 48 hours 95%.
3. The consultation report, ER discharge instructions, or hospital discharge report were signed and dated within 48 hours 48%.

In record reviews, I identified 30 deficiencies that relate to this provision. Many of the deficiencies relate to not obtaining a report of the consultation. This is a serious problem as the plan of care remains uninformed when the consultants diagnosis and treatment plan are not known. DPSCS should work diligently to obtain consultation reports and hospital discharge summaries. The "after-visit" summary is the most frequent hospital discharge document present. This is not a discharge summary and gives insufficient information to inform the plan of care. Providers can no longer utilize CRISP, which previously was a major source of obtaining history of the patient's civilian treatment. CRISP is no longer available because CRISP now requires two-step authentication to enter the CRISP portal. DPSCS should permit providers to carry cell phones in order to conduct two-step authentication so that they can access CRISP. Important information from CRISP should be copied and pasted to a document and scanned to the medical record to inform regarding the plan of care and management of patients. CRISP entries should be so labeled in the medical record so that they can be located.

Record reviews show that some patients are not timely seen after consultations or hospitalizations and recommendations for further referrals or medications are unrecognized. This problem is contributed to by the DPSCS policy not specifying a timeframe for review of consultant reports. DPSCS policy give providers a month to meet with the patient and discuss the consultant's recommendations and how it will change the plan of care. Upon return from an offsite consultation, hospitalization, or emergency room visit, all patients need to return to a designated location (the dispensary or sally port) and the incoming paperwork should be reviewed by a provider promptly. Any new recommended medication should be ordered. If the provider disagrees with the consultant's recommendation an explanation should be documented in the record. Any recommended referrals should be promptly ordered or the provider should document in the record an explanation why the recommendation was not adhered to. If a provider is unavailable, a nurse should evaluate the patient and call an on-call provider for a prescription for any recommended medication and the paperwork should be reviewed by a provider the following morning. Currently, returns from the offsite care appear chaotic and it is not clear how medication or referral recommendations are reviewed.

The Settlement Agreement requires that the medical record contain the date of any consultation. DPSCS has no policy requirement and there is no practice of patients returning to a central location upon return from an offsite encounter so the record has no documentation of offsite events. One can only find this information by opening multiple dated note surrounding a date presumed to be the consultation date (which is not identified in the medical record) to identify whether anyone documents a consultation date. All offsite movements for medical purposes must be documented in the record. A way to ensure this occurs is to modify policy to require that patients returning to BCBIC from offsite encounters do so to a central location (preferably the dispensary). When a patient returns from an offsite visit to a central location, the note should be labeled as an "offsite return". At the "offsite return" a provider should review the returning paperwork and ensure that any recommended medications are ordered or a reason given why they should not be ordered. Any recommended follow up consultations or referrals should be promptly made or a reason given for not doing so. If a provider is unavailable, a nurse should document an "offsite return" note and call a provider for any recommended medication orders. When a nurse completes an "offsite return" a provider must review paperwork the following day and document and order any recommended referrals and ensure medications were ordered appropriately.

In addition, the primary provider for the patient should evaluate the patient within a week to discuss changes in medications and how the treatment plan will be updated based on the consultation.

An example of why this is necessary is a patient[92] who went offsite to a vascular surgery consultation. At a later date, at a 11/18/22 nephrology consultant visit, the nephrologist documented that the patient returned from vascular surgery and earlier had his ultrasound. Neither the vascular surgery consultant report, the ultrasound report nor any recommendations were available in the record and there was no evidence in the record when either consultation occurred.

In summary, this provision remains noncompliant because DPSCS has not audited all requirements of this provision of the Settlement Agreement. In particular consultations are only evaluated in the audit if they are completed not if they are just requested. Requested consultations are specifically called out in this provision of the Settlement Agreement. The appointment date for upcoming consultations is unavailable to providers and is not in the medical record even though it is required by the Settlement Agreement. Information on follow up requires a consultation report or hospital discharge summary but these are frequently unavailable. Also, record reviews show poor performance regarding this provision.

Four recommendations were made related to this provision in the prior report. Recommendation 3 for the YesCare utilization physician to document their decision in the record has been partly accomplished except the utilization physician does not document their name and does not consistently refer to the precise consultation they are performing utilization on. This recommendation was duplicated in 22a and a revised recommendation is present in recommendation 1 in section 22a above. The remaining three recommendations were not addressed. Three recommendations were added based on findings in record reviews and based on evaluation of the Combined Chart Summary.

Recommendations:

1. Perform a root cause analysis of obtaining specialty care reports, identify deficiencies and take corrective action. Based on this information, a workflow of an acceptable process for ordering and managing specialty care referral should be implemented in the new electronic medical record.
2. Track on a monthly basis and report findings to the quality committee the number and percent of reports obtain from offsite consultants and diagnostic testing centers within 7 days. Also report the total number of reports received regardless of the timeliness. After-care summaries should not be considered reports.
3. Consider improving the audit to include requirements of the Settlement Agreement and DPSCS policy.
4. Modify the consultations link in the Combined Chart Summary as recommended above.
5. Policy should require that all patients arriving to the facility from offsite consultations should be evaluated in a central location (preferably the dispensary). Upon return, a provider should review the returning paperwork and ensure that any recommended medications are ordered or a reason given why they should not be ordered. Any recommended follow up consultations or referrals should be promptly made or a reason

[92] Patient 1

given for not doing so. When a provider is unavailable, a nurse should promptly call a provider if any medications were ordered for a verbal order and a provider should review the paperwork the following day. The nurse in the dispensary needs to document that the patient returned from an offsite visit.

6. Policy should require that within a week after offsite consultation or hospitalization a provider responsible for the patient's care needs to meet with the patient and discuss any changes to the plan of care based on findings or outcomes of the recent consultation or hospitalization. This should be sooner if clinically indicated.
7. DPSCS should permit providers to have cell phones so that they can complete two-step authentication in order to access CRISP.

Settlement Agreement Statement: 22.e. *For the purpose of this Settlement Agreement, referrals for mental health services that are provided onsite at BCDC or BCBIC do not constitute specialist referrals.*

Compliance Rating: Not Evaluated

SICK CALL

Provision 23 Compliance: Substantial Compliance

Settlement Agreement Statement: 23.a. *Plaintiffs shall daily have the opportunity to request health care. Nursing staff shall make daily rounds to collect sick call requests from plaintiffs who have no access to a sick call box.*

Compliance Rating: Substantial Compliance

Findings:

No change has been identified to the pickup of sick call requests. 7594 requests were logged for males and 1388 requests for females or a combined approximately 1500 health requests a month. This item is still substantially compliant.

Recommendations:

1. Track pick up of tracking logs and health request slips on a daily basis and provide monthly aggregate report to the quality improvement committee.
2. Continue to track the number of health request slips picked up daily using the tracking slips and make sure this matches the number of slips triaged daily.
3. Memorialize this process in a document to ensure that it is standardized so that staff can be trained against a standardized process.

Settlement Agreement Statement: 23.b. *Requests for health care shall be triaged by RNs within 24 hours of receipt, with receipt measured from the time that the requests arrive at the site of triage following daily collection of sick call slips.*

Compliance Rating: Substantial Compliance

Findings:

The time to triage of the 7594 requests was 2.74 hours for males. For the 1388 requests for females, the time to triage was 2.45 hours. This remains substantially compliant.

Recommendations:

1. Continue to train triaging nurses on appropriate triaging based on suggestions in the November 2020 report.
2. Make triaging of complaints part of annual clinical updates for nurses.

Settlement Agreement Statement: 23.c. *Plaintiffs whose requests include reports of clinical symptoms shall have a face-to-face (in person or via video conference, if clinically appropriate) encounter with a Medical Professional (not including an LPN) or Mental Health Professional within 48 hours (72 hours on weekends) of the receipt of the request by nursing staff at the site of triage, or sooner if clinically indicated.*

Compliance Rating: Substantial Compliance

Findings:

For all visits the average time for face-to-face evaluation was 1.74 days for males and 1.95 days for females. This remains substantially compliant.

Recommendations:

1. Improve the documentation on the sick call log so that all items are filled out. Also, identify whether the complaint requires a nurse to evaluate the complaint and whether medical complaints are symptomatic.

2. Develop a method to evaluate quality for nurses, mid-level providers and physicians.

Settlement Agreement Statement: 23.d. *Care at sick call and at subsequent follow-up appointments shall be as determined by appropriate Medical Professionals and/or Mental Health Professionals, in the exercise of appropriate clinical judgment, to meet the plaintiffs' medical and mental health needs.*

Compliance Rating: Substantial Compliance

Findings: The majority of health request have a face to face encounter with a mid-level provider. Ten records were reviewed for health requests. All were evaluated by mid-level providers and all requests were adequately and timely evaluated. This item remains substantially compliant.

Recommendations:

1. Develop audits to measure the quality of nurse and provider evaluations of health requests. Ensure that the appropriate professional performs these audits; nurses evaluate nurses and physicians review provider health request evaluations.

MEDICAL RECORDS

Provision 24 Compliance: Partial Compliance

Settlement Agreement Statement: 24.a. *The Commissioner shall promulgate and implement policy and procedure to ensure that the medical records of plaintiffs are available at sick call and other encounters with Medical Professionals and Mental Health Professionals. An on-site Medical Professional or Mental Health Professional who is providing treatment, including diagnostic services, to a plaintiff shall have access to both the EMR and any non-electronic portion of the medical record, unless the need for emergency treatment precludes access at the plaintiff's location.*

Compliance Rating: Partial Compliance

Findings:

There was an earlier upgrade of the current electronic record sometime last year and then again in November or December of 2022. The DPSCS Information Technology and Communication Division (ITCD) is in charge of the implementation. In the last report DPSCS provided a timeline to implement 16 items by 12/15/22[93]. These included the following key functions.

1. IMMS created in NextGen
2. Combined Summary with all disciplines most pertinent information
3. Care guidelines
4. Care quality
5. Document management process
6. Interface with OCMS
7. Mental health workflows revamped
8. Documents that can be signed within the system
9. Consult template updated
10. eZmar
11. New reports
12. Updated reports
13. Separate problem lists for medical and mental health
14. Medical dashboard in OCMS
15. Various process improvements
16. LMS training created

The IMMS has not yet been implemented in NextGen. The eZmar has not been implemented. The consult template and combined chart summary have problems. Reports have not worked as

[93] This is based on responses of DPSCS regarding the implementation of NextGen found in Appendix A of the last report September 2022.

anticipated and DPSCS is uncertain whether it can obtain data it expected it could obtain. The problem list has multiple bugs. Interfaces were all supposed to be completed but it appears that there may be problems with the interfaces or there may be process errors that appear as interface issues.

ITCD began live implementation before the product had been developed and fully tested and the results were unsatisfactory. Multiple bugs and process issues have arisen and are being identified by staff. ITCD established a process for receiving the bugs and works through these as they can but many staff have indicated bugs they have reported have not been addressed. More and more, medical record problems are becoming clinical problems because the design of the record continues to impair clinical staff from functioning effectively. Implementing an electronic record is challenging and this implementation is no different. DPSCS has been attempting to implement a record for several years without success. It may be useful for ITCD to obtain assistance from a professional consultant or a company that can assist in the implementation, development of interfaces, and in establishing ability to obtain data necessary to verify compliance.

In record reviews and in discussion with providers the following defects or deficiencies were found.

1. Many records I opened showed that the patient had two to three electronic records for each patient. Each of these records may have clinical information in them. Also, there may be additional records found if one searches for the patient by date of birth. This is a significant problem especially if providers enter data into the wrong record. ITCD has not yet corrected this problem but are aware of it. This problem, apparently, is partly responsible for laboratory tests not being forwarded into the electronic record.
2. Onsite consultants do not all have training in use of the medical record. One consultant writes notes on paper but tried to schedule a patient for a referral but did not succeed and apparently did not know how to refer the patient for a test and a consultation. All staff should be trained.
3. One consultant uses the electronic record but his notes are filed as routine provider notes. His notes are not recognizable as a consultant so to find his consultation reports one must open every note in the time span where he may have seen the patient. This is extremely tedious. His notes should be labeled as a consultant note so they can be recognized.
4. A widespread problem is that multiple patients are listed on the banner bar as deceased when they are not. ITCD acknowledges awareness of the issue but has not yet been able to fix the problem.
5. Phlebotomist appear able to modify laboratory test orders[94] apparently without provider approval.
6. The date/time stamp when a completed laboratory test is inserted into the record is not available. All test results have a time of 00:00 or midnight of apparently the date of order or phlebotomy. Therefore, verification of provision 19e is difficult if not impossible to perform. Also, provision 19f is made difficult.

[94] See patient 1 in medical record reviews on 10/6/22.

7. Progress notes by staff are permitted to be kept open for an extended period of time[95]. I have asked for confirmation of this time period. This affects provisions 19.e.i. and 17b which are time sensitive. Notes should be generated at the time of service or shortly thereafter.
8. Documentation of review of laboratory test results is found on the order module →NextGen status column as "signed off". However, the date/time of sign off is not available. This affects 19e.
9. The nursing plan of care does not describe a nursing plan of care consistent with the physician plan of care for the patient. With respect to provision 18, the nursing plan of care on the infirmary needs to be consistent with the plan of care for the patient. The medical record template for nursing infirmary care was not designed with the plan of care in mind and needs redesign.
10. There are three problem lists[96], none of which auto-populates to the assessment and plan. The three problem lists are typically different one from another. Assessments do not typically match problem lists. This makes it difficult to attain compliance with provision 18a.
11. Order management is not standardized and needs reworking. There are multiple ways for physicians to write orders and the multiplicity of ways to write orders results in fragmented and dysfunctional reporting of orders and order results. It is often very difficult to find orders because it depends on how something is ordered. This affects any provision that entails an order.
12. Order sets for detoxification monitoring (COWS and CIWA) are imprecise. In one patient[97] an order for COWS monitoring was "withdrawal monitoring – alcohol and drug". This order does not have a specific meaning. If "drug monitoring" means COWS then the order should be "COWS monitoring". The frequency of monitoring and length of monitoring should be in the order; how else will a nurse know how to implement the order? Typically, COWS or CIWA orders start at three times a day but in persons whose symptoms are resolving the interval of testing can be reduced or may need to be increased. At times the monitoring may need to be more frequent. Providers should be able to order what they clinically need but this does not appear to be the case. Order sets should be determined in discussions with the providers. If physicians cannot order what they need to order, it's not possible to determine an appropriate plan of care. If the order is a generic order like "withdrawal monitoring" and "withdrawal monitoring" is not defined, then the order is subject to interpretation of individual nurses and optionally done which appears to be happening.
13. There is a consultation and a referral template. Initially, this caused considerable confusion with providers who were not certain which was to be used to order specialty care. On the printed consultation template, the new requests are combined with prior referrals in a column so it is difficult to determine which referral is the requested referral. The referral template is overly complex and produces some notes that contain multiple pages of

[95] I actually obtained three different responses to this. One staff member told me that the chart locked out after 24 hours, another said 48 hours, and a third said 72 hours. On record review I found someone whose note extended for about 18 hours.
[96] One problem list is on the banner bar of the medical record. The second is in the beginning of the note. The third is below the first and is titled Problem List not yet mapped to SNOMED. Typically, these problem lists are not the same.
[97] Patient 19

irrelevant information that make it difficult to determine what the referral is for or its urgency. Because there are multiple methods of ordering a consultation, there are multiple ways that the referral is printed. There should be a single way to order a consultation that is concise, accurate, and brief. The consultation template needs revision.

14. In some cases, filling out a consultation template does not result in a utilization review. This appears to be either a design issue or a training issue that was not anticipated.
15. Notes occasionally appear with auto-filled irrelevant information. It does not appear that ITCD did enough work in advance to pilot and test the product to ensure irrelevant auto-fill was excluded.
16. Consultation requests, when printed, often look different depending on the physician who authors the referral. This implies that the template is not standardized and permits too many optional ways of ordering.
17. The template for the transfer note between BCBIC and the prison or between BCBIC and the infirmary needs revision. The med_chm_transfer_send note[98] is filled with irrelevant information and should be truncated and more carefully thought out. It currently includes apparently all Mantoux skin tests ever obtained; the dosage of purified protein derivative (PPD) used for the Mantoux skin test for multiple years; years of orders for blood tests; years of orders for Mantoux skin testing; and a variety of orders for clinic visits which apparently were mis-ordered as specialty visits. Whatever template was used to produce this note should be revised as it provides little useful information; provides much information that is irrelevant; and lacks important information that should be provided.
18. Presentation of COWS and CIWA data is not standardized. Sometimes these tests are documented in a nursing note and sometimes they are presented in a table. The presentation of these results should be standardized but is not.
19. There were numerous complaints about the task list with respect to provision 19c. Whether this is a problem with the electronic record or something else is not clear.
20. Requests for specialty care documented as completed in progress notes do not consistently appear to result in successfully completed referrals[99]. This may be related to the template, training, or something else.
21. The medical record does not inform if a consultation is completed or is pending. If a consultation is pending, the date of the consultation is not available. The Combined Chart Summary should include the date an upcoming appointment is scheduled or include documentation that the appointment has not yet been scheduled. Physicians are uninformed with respect to the status of ordered specialty care.
22. Only one consult can be written per encounter which creates opportunities for error and create unnecessary work. A provider should be able to order as many consultations as are required.
23. According to providers, orders for certain non-standard items are not possible in the system. I was unable to obtain examples.
24. According to providers, intake staff have difficulty ordering equipment and housing for ADA patients.

[98] The example used is patient 4 on 5/27/22 at 11:20 am

[99] See for example patient 23. On 11/18/22, a provider documented on the progress note that a colonoscopy was ordered. The referral form for that visit contained multiple prior referrals but did not contain the colonoscopy. It appeared that the provider failed to adequately make the order. I have been told that only one consultation can be ordered per encounter. This may have occurred as another referral was made.

25. There is a pharmacy bug that is dangerous but unresolved. A provider ordered but cancelled a medication order. The pharmacy continued to produce medication administration records to nurses to administer the medication for four months even though there was no order for the medication in the medical record. This speaks to a problem with the interface between the electronic record and pharmacy. This is a patient safety risk that must be corrected as soon as possible.
26. Written orders as represented in the Chm Home Page are sometimes different from the documented plan of care in the progress notes. This may result from order sets that restrict providers from ordering care as appropriate.
27. Admission to the infirmary does not appear in orders.
28. Some ADA durable medical equipment (e.g., beds) are not ordered in the EPHR as a formal physician order. Instead, it appears these are ordered by notes to the administrator. Orders are orders and should appear as such.
29. ADA accommodations ordered in progress notes do not consistently appear in orders.
30. Staff are unaware when an IMMS intake screening is not completed.
31. The precise location of the patient is not present on medical notes. The location of patients need to be present on banner bar and on all opened notes in the medical record. The location needs to be to the bed so that low bunk orders can be verified.
32. There should be a standardized protocol for scanning documents to the medical record. Several scanned notes were in unrecognizable locations.
33. The physician progress note to document the plan of care was not well thought out in advance of the implementation. Few assessments contain all of the problems of the patient and the problem list is a mess.
34. Order sets for medications are not all consistent with contemporary standards and require workarounds to order. This is true for sexually transmitted disease treatment.
35. It is not possible to order tapering doses of medication for detoxification. I could not verify if this is true also for oral steroids or other medications. This is inappropriate practice.
36. There is no visual indicator, notification, or alert of a need for medication renewal. So, medication can expire without anyone noticing. An alert should be available on the banner bar for expiring medications that when opened should list the expiring medication and a way to renew.
37. Orders for ADA referral are not included on the orders. These are not ordered through the medical record making them difficult to verify.

These are only a list of problems identified through record reviews and a brief discussion with staff.

There are several issues that deserve more detail. An issue that needs to be addressed is that DPSCS permits all provider notes to be kept "open" for an extended period of time. One provider said notes could be kept open for 48 hours, another said 72 hours, a third said 24 hours. This has significant impact for provision 17b, 19e.i, and possibly 17a and can change scoring. Notes are best generated at the time of service or shortly thereafter. A delayed note is understandable under unusual circumstances, but it appears in DPSCS that many providers save notes and complete them at a later hour as a routine. In record reviews, notes are frequently delayed from three to five hours,

but many notes are delayed further. The longest delay on a review of 21 records was almost 18 hours. Because 17a, 17b, and 19e are affected by the date/time stamp, I will audit using the closing time of the note for the measure of whether the note was timely. In general, I agree with the advice of Medicare[100] which states, "Medicare expects notes to be generated *at the time of service or shortly thereafter*. Delayed entries within a reasonable time frame (24-48 hours) are acceptable *for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service".* It appears that delayed entries are not done because of clarification, error correction, addition of additional information, or unusual circumstances prevent generation of a note at the time of service, but because it is for convenience of staff or a typical practice to write notes after the time of service related to trying to get work done. DPSCS permits all physicians to utilize the delayed entry timeframe for all notes and extends the delay to 48-72 hours. Notes should be contemporaneous with the evaluation. If a provider has something to add later, an addendum can be added. DPSCS should develop policy and procedure on this topic. This topic should be discussed with providers to develop a reasonable and safe practice.

Another issue that deserves mention is the problem list. The International Classification of Diseases (ICD) is a system to classify diseases, symptoms, abnormal finding, complaints, and external causes of injury or disease. The ICD-10 is the 10th version of the ICD. The ICD-10 has over 69,000 diagnosis codes. The ICD-10 is universally used in the United States because the ICD-10 must be used to submit claims and is a requirement of the Health Insurance Portability and Accountability Act (HIPPA). Because it is required for billing purposes, it is widely used. The jail doesn't bill and I know of no other regulations that require use of ICD use except for billing.

The NextGen product apparently requires providers to select the closest available diagnosis from an ICD-10 list which may or may not approximate the disease in question. This becomes an exercise of providers picking from a bewildering array of diagnoses which makes the problem lists dysfunctional. DPSCS should work to truncate the range of problems from the ICD-10 to obtain a list for the most common diseases and allow providers to choose from the ICD-10 for unusual problems. Providers should be capable of changing the problem list. Currently, problem lists are inaccurate. They include symptoms, temporary problems that are quickly remedied, problems that don't require chronic medical management (near or far-sightedness), or are duplications of other listed problems. DPSCS should re-evaluate the problem list, determine how providers are to choose from the ICD-10 codes, and attempt to standardize problem assignment in a manner that helps organize care. This should result in a standardized procedure. This should have been done prior to implementation of the record but should still be attempted now as it is causing dysfunction and is a barrier to compliance with provision 18. Providers have also told me that, at times, when they delete problems from the problem list the problems are still present on the problem list. The reason for this should be identified and this should be corrected.

Record reviews show a deterioration in provider notes that is, in part, related to providers no longer being able to access CRISP because CRISP now requires dual authentication when signing on. Dual authentication requires a cell phone to receive a text with an authentication code. BCBIC prohibits providers from keeping cell phones but needs to re-consider this prohibition as it prevents

[100] Medicare B Update; Newsletter for Connecticut and Florida Medicare Providers, third quarter 2006, Volume 4 Number 3 as found at https://medicare.fcso.com/Publications_B/2006/141067.pdf

providers from accessing this important service. When CRISP service terminated, providers were reliant on medical records to obtain medical records from specialists and hospitals which is not working well. Medical records are frequently not obtained from consultants or hospitals or only an "after-summary" is obtained which lacks details of what occurred clinically at the visit. Clinical care has suffered.

ITCD stated that it may not be able to obtain data from the existing medical record in a form that allows them to use data to verify compliance. Currently, staff are attempting to obtain data through Crystal Reports[101] from the medical record but are unable to either get the data or get useable data satisfactory for the need. ITCD and DPSCS are deliberating on what to do going forward.

The electronic medication administration record continues to be delayed and there is not clear visibility to the implementation. As a result, DPSCS should immediately begin scanning all medication administration records to the electronic record on a month by month basis by scanning each month of medication records to the last day of the month.

There are multiple ways to enter notes and orders which cause errors. This may result from lack of training. Because training appears to have been ineffective, DPSCS should evaluate their training methodology. Typically, training is provided in a physical location dedicated for that purpose. There is space where each trainee has a computer where a trainer can give instruction in a space conducive to learning. DPSCS should establish this type of training. DPSCS should ask a professional who has experience implementing an electronic record about sizing such a location and attempt to locate a space. If a space cannot be located onsite, I would strongly recommend renting a space during a six month period when the record is ready for full implementation. One problem is that ITCD had initiated a rolling installation which currently has no clear end in sight and it is difficult to establish a time to begin training.

Six recommendations were made in the previous report. Recommendation 1 to obtain a new electronic record was cancelled but an upgrade of the existing record continues incrementally without a firm end date. Recommendation 2 to revise procedures based on anticipated electronic record processes has not been enacted. This recommendation needs to include a policy on when providers can keep notes "open". Recommendation 3 and 4 have not been initiated. Regarding recommendation 5, a crude device survey was completed by an administrator[102] who completed a walk around to observe and count devices. This was not based on any metric or workload analysis of how many staff work and what those staff need to do. Despite this observational count, DPSCS still recognized a need for devices and has been adding tablet computers as they can afford. A formal device survey should still be done. DPSCS feels that recommendation 6 and 7 are unnecessary to achieve compliance and are not required by the Settlement Agreement. Nevertheless, without the appropriate expertise and staff DPSCS and ITCD continue to struggle in the implementation of the record and in the acquisition of data. I continue to strongly recommend items 6 and 7.

[101] Crystal Report is a software that allows an individual to create reports from a data source.
[102] As represented in an email from Natausha Pinder on 9/15/22

Recommendation 7.a.ii., and recommendation 8 are new recommendations that are given due to the delays in implementation of the electronic record.

Recommendations:

1. Obtain a new electronic medical record.
2. Review and revise policies based on new process changes and based on anticipated electronic record processes.
3. Ensure that dental records are available to other clinicians.
4. Consider and plan for the training function with the implementation of the electronic medical record. Ensure that interactive training occurs that is based on expected assignments.
5. Perform a device survey prior to implementation of the new electronic record that includes space requirements.
6. Hire data staff to ensure data from the record will be available for verification of the Settlement Agreement.
7. With respect to implementation of the electronic record, DPSCS should consider the following:
    a. Establish an electronic record implementation project team to consist of
        i. A lead person from the electronic software vendor who can be available at least one day a week at BCBIC to meet with subject matter experts (doctors and nurses) from BCBIC to evaluate and give comments on screens in the electronic record relevant to their area of expertise so that the vendor can modify those screens accordingly. This should occur weekly until all screens and workflows relevant to subject matter experts are completed.
        ii. Hire a professional consultant or a company to lead the implementation of the electronic record and establishment of a data warehouse and ensure all interfaces are completely installed;
        iii. A person who is competent in process analysis who can assist in analysis of key workflows associated with current defective processes[103] required by provisions of the Settlement Agreement and assist in implementation of the electronic record associated with those processes;
        iv. A physician leader who understands existing workflows and is familiar with the existing electronic record; and
        v. BCBIC subject matter experts (physicians, nurses, medical records staff, etc.) who can participate in evaluation and improvement of screens and workflow design relevant to their area of expertise in the electronic medical record.
    b. Map critical practice workflows
        i. Hire, obtain consultant(s),or appoint from existing staff a qualified process analyst who can map workflows of critical processes and assist in implementation of the electronic record.
        ii. Ensure that workflows for the recommended root cause analyses are addressed with implementation of the electronic record. This should initially focus on the following.
            1. Orders of all types as documented in recommended root cause analyses,

[103] These are processes which have been called out in prior reports as requiring root cause analyses.

2. Task lists for nurses, phlebotomists, and staff as they relate to provider orders,
3. Transferring information obtained from orders (e.g., results of vital signs and capillary blood glucose values) to useable and easily obtainable information in provider electronic record templates (e.g., provider progress notes).
4. Workflows concerning all root cause analyses associated with medication management.

c. Establish a test environment and a location at BCBIC where subject matter experts can meet weekly with the process analyst and vendor lead to discuss and modify screen presentations until acceptable product is completed.

8. Scan all medication administration records to the electronic record to the last day of the month for the month of service.
9. Create a training center for approximately twenty persons at a time. There should be sufficient devices so each trainee as a device. There should be a large screen so that the trainer can provide examples.

Compliance Ratings Summary			
	May-22	Sep-22	Mar-23
Provision			
17	Partial Compliance	Partial Compliance	Partial Compliance
17a	Partial Compliance	Partial Compliance	Partial Compliance
17b	Substantial Compliance	Partial Compliance	Partial Compliance
17d	Partial Compliance	Partial Compliance	Partial Compliance
17e	Partial Compliance	Partial Compliance	Partial Compliance
18	Partial Compliance	Partial Compliance	Partial Compliance
18a	Partial Compliance	Partial Compliance	Partial Compliance
18b	Partial Compliance	Partial Compliance	Partial Compliance
18c	Partial Compliance	Partial Compliance	Partial Compliance
18d	Partial Compliance	Partial Compliance	Partial Compliance
18e	Substantial Compliance	Partial Compliance	Partial Compliance
18f	Partial Compliance	Partial Compliance	Partial Compliance
19	Noncompliance	Noncompliance	Noncompliance
19a	Noncompliance	Noncompliance	Partial Compliance
19b	Noncompliance	Partial Compliance	Partial Compliance
19c	Noncompliance	Noncompliance	Noncompliance
19d	Noncompliance	Noncompliance	Partial Compliance
19e	Noncompliance	Noncompliance	Noncompliance
19f	Noncompliance	Noncompliance	Noncompliance
19g	Noncompliance	Noncompliance	Noncompliance
20	Partial Compliance	Partial Compliance	Partial Compliance
20a	Partial Compliance	Partial Compliance	Partial Compliance
20b	Partial Compliance	Partial Compliance	Partial Compliance
20c	Substantial Compliance	Partial Compliance	Partial Compliance
20d	Partial Compliance	Partial Compliance	Partial Compliance
20e	Substantial Compliance	Substantial Compliance	Substantial Compliance
20f	Substantial Compliance	Substantial Compliance	Substantial Compliance
20g	Substantial Compliance	Substantial Compliance	Substantial Compliance
21	Partial Compliance	Partial Compliance	Partial Compliance
21a	Partial Compliance	Partial Compliance	Partial Compliance
21b	Substantial Compliance	Partial Compliance	Partial Compliance
21c	Partial Compliance	Partial Compliance	Partial Compliance
21d	Substantial Compliance	Substantial Compliance	Substantial Compliance
22	Noncompliance	Noncompliance	Noncompliance
22a	Partial Compliance	Partial Compliance	Partial Compliance
22b	Noncompliance	Noncompliance	Noncompliance
22c	Noncompliance	Noncompliance	Noncompliance
22d	Noncompliance	Noncompliance	Noncompliance
23	Substantial Compliance	Substantial Compliance	Substantial Compliance
23a	Substantial Compliance	Substantial Compliance	Substantial Compliance
23b	Substantial Compliance	Substantial Compliance	Substantial Compliance
23c	Substantial Compliance	Substantial Compliance	Substantial Compliance
23d	Substantial Compliance	Substantial Compliance	Substantial Compliance
24	Partial Compliance	Partial Compliance	Partial Compliance
24a	Partial Compliance	Partial Compliance	Partial Compliance

Record Reviews March,
2023 Medical Report

Patient 1

This patient initially appeared to have no IMMS intake screening. Upon asking a DPSCS staff member I was told that he had two records and one of them had the IMMS. The record with the IMMS did not have the remainder of his medical record so unless one knew that there were two different medical records, one would not know this error **(24).** The medical record also recorded on the banner bar that this inmate was deceased, which is not accurate **(24)**. The IMMS was performed on 8/11/22 at 5:03 pm. The blood pressure was mildly elevated (141/81). All questions were answered "no" and the patient was referred for routine evaluation. This patient had chronic kidney disease which was not identified. He had it as a child but the questions did not identify this problem **(17a)**.

An intake assessment was performed on 8/16/22 at 5:34 pm. The problem list contained three problems that were not problems that needed tracking with respect to provision 18 (far-sighted, smoking and alopecia). Smoking is an important modifiable risk factor but is not a chronic problem that requires tracking unless providers are actively engaging the patient is a smoking cessation program. His far-sightedness is not a chronic problem that needs monitoring because a visit to the optometrist should result in corrective lenses. The alopecia is also not a medical condition requiring continued monitoring. These clutter the problem list **(18a).** The provider documented that the patient denied any medical problems but this failed to identify the patient's prior kidney disorder **(17b)**. The blood pressure was higher (146/92 and 145/83) than it was at the IMMS screening but it was ignored as a problem **(17b, 18a)**. The provider documented that the HCV test was non-reactive but the test result was not found in the results tab **(19f)**.

On 9/27/22 a provider saw the patient for ringing in his ears. The physical examination was auto-filled and documented as normal but did not include examination of the tympanic membrane and ordered antibiotics for otitis media without having documented an examination consistent with otitis media **(18c)**. The auto-fill function is problematic.

A provider saw the patient on 10/4/22 for follow up of the ringing in his ears and documented that the patient was also being seen for hypertension which had not been identified. He noted that the patient had prior hypertension but could not remember the last time he saw a physician for this. The blood pressure was elevated (144/82). The plan of care was appropriate. Antihypertensive medication was started and blood tests were ordered with an order date in the progress note on 10/4/22 at 12:14 pm. The laboratory tests ordered included CBC, CMP, lipid screen, A1c, TSH, UA, Hepatitis C, and HIV.

The date/time stamps of laboratory orders and reviews are confusing.

- The test mentioned above was ordered on 10/4/22 at 12:14 pm.
- The test was drawn by a phlebotomist on 10/5/22 at 5:44 pm.
- The result was documented in the medical record at 00:00 [midnight] on 10/5/22 which was before it was drawn. This appears related to the date of phlebotomy.

- At 2:43 pm on 10/6/22 a nurse documented receiving a critical laboratory result, apparently by phone. A doctor's note appeared appended to the nursing note.
- The doctor's note was opened at 10/6/22 at 2:43 pm, the identical time as the nurse note, but was completed on 10/7/22 at 8:23 am, a span of 17 hours, 40 minutes. When did the doctor see the patient at 4/13/22; at 2:43 pm or at 10/7/22 at 8:23 am, and when was the laboratory test reviewed? This cannot be determined from the note.
- The order module tab→sign-off and tracking comments tab documents that the critical creatinine value of 4.88 was seen on 10/7/22 at 1:34 pm by a different doctor than the one who wrote the note from 10/6/22.
- The test order for 10/6/22 for was documented in the orders module as "ordered" which means not yet done.
- The ferritin which was ordered on 10/6/22 but not on 10/4/22 was reported in the results tab as completed at midnight on 10/5/22.

Because the ordering and reporting process has not been appropriately mapped out, this reporting system is unreliable, at least for 19e and 19f. ITCD needs to re-evaluate this process more carefully.

On 10/6/22 a doctor documented that the laboratory called with a critical creatinine. The laboratory tests were not yet in electronic record **(18a, 19f)**. The doctor re-ordered labs (CMP, TIBC, iron, and CBC,) and added two tests (ferritin and microalbumin).

- The order for the CMP, A1c, CBC, iron, TIBC, ferritin, microalbumin, and UA were re-ordered.
- These orders appeared as never done on the order module but on the order module→sign off and tracking comments module dated 10/7/22 at 10:31 am a phlebotomist documented that the tests were drawn but on 10/12/22 at 4:47 pm a phlebotomist documented that the lab was "added on to the specimen sent on the 5th". The ferritin ordered 10/6/22 appeared on the tests ordered 10/4/22 but appearing 10/5/22 in the results section. What this means is that the phlebotomist apparently decided that, because the only difference between the tests ordered on 10/4/22 from the tests ordered on 10/6/22 was a ferritin and a microalbumin, the orders could be combined. The ordering provider was not contacted for approval. Phlebotomists should not be authorized to do this.

The provider ordered an urgent consultation to nephrology which was appropriate. These laboratory results from 10/6/22 were not completed. Apparently what occurred is the phlebotomist decided that since the only difference between the order from 10/4/22 and 10/6/22 was the ferritin test. So, technician documented in the order module comment section that the ferritin was added on to the specimen drawn on the order module

On 10/7/22 the lab results from 10/4/22 were available. The doctor noted that the patient's lipids were elevated but the plan was diet control. This patient had a 10-year cardiovascular risk of 21.7% for which a statin is recommended **(18a)**.

On 10/12/22 a doctor saw the patient and documented that ordered labs were not done. The phlebotomist was emailed **(18a, 19e)**.

The lab called a physician on 10/14/22 that the creatinine was now 5.74 a critical value. The doctor called the nephrologist to expedite the consultation which occurred on 10/19/22. The on-site nephrologist did not enter his note into the electronic record but hand wrote a note that was scanned to the record. The nephrologist should be trained to use the electronic record **(24)**. The nephrologist ordered a renal ultrasound, a random urine for protein/creatinine, PTH, vitamin D levels and referred the patient to vascular surgery for evaluation for a shunt for dialysis. He ordered sodium bicarbonate and calcium acetate with follow up in two months. Because the nephrologist didn't use the electronic record, his orders were picked up at later times by several providers. The calcium wasn't ordered until 10/20/22[1]. The sodium bicarbonate wasn't ordered until 10/25/22 (**18a**). The nephrologist attempted to use the electronic record to order the referrals but failed to refer for an ultrasound **(18d, 22a, 22b)** but attempted to refer for vascular surgery. This referral wasn't approved until 10/27/22 **(22b)**. The ultrasound was referred 10/19/22 and again on 10/25/22. The approval for the ultrasound was found on a 10/25/22 date but the approval was dated 10/28/22. This was not a timely utilization review **(22b)**. Why this test needed two referrals is a reflection of the lack of physician knowledge of pending consults which should be available in the medical record **(22d)**.

On 11/2/22 the provider note documented 15 problems. Four were variants of chronic kidney disease and these four could have been replaced with one problem. Hypertension with albuminuria and hypertension were repetitive as well. Hyperparathyroidism was listed twice. Itching is not a chronic problem. Tinnitus is an episodic problem and not a chronic problem. Varicose veins did not appear to be a chronic problem as it did not require any intervention. There were only two assessments and they were for the same problem. The problem list on the banner bar had 10 problems listed. One (perforated eardrum) is an episodic problem. Another (itching of the skin) is not a chronic problem requiring medical intervention. Another (varicose veins) did not require medical intervention. Far-sightedness was also a problem that is corrected with glasses and is not a chronic problem requiring medical intervention. The problem list did not map to the assessment section and this is a major deficiency with respect to provision 18. Until the problem list is accurate and maps completely to the assessment, the plan of care will be deficient **(18a)**. This problem is repeated on many progress notes.

On 10/20/22 the order summary tab documented that a provider signed off on multiple labs. It was unclear what labs were being signed off. Was it labs from 10/5/22 or 10/13/22? Except for progress notes, there is no means to verify timeliness of laboratory test review. Progress notes inconsistently document review of laboratory results **(19e)**.

A critical creatinine level result of 5.67 was reported in the lab flowsheet at 00:00 [midnight] on 10/24/22. The electronic record does not record the time the specimen was received in the laboratory nor the time that they inputted the result. At 4:13 pm on 10/25/22 a nurse documented that the lab called for a critical value.[2] This time difference between when the test is recorded in

[1] The calcium test was part of a larger order placed at 12:30 am on 10/20/22 by a provider who opened a note at 8:27 pm on 10/19/22 and closed the note at 12:34 am on 10/20/22. In this case the order was made separately from the note verifying that there are a variety of w

[2] Was informed by staff that there is a critical lab form that is in place for nursing to fill out when receiving abnormal labs from the laboratory. This form is not present in the chart. The electronic record should have a template to receive a critical laboratory result that nursing can use and that would be date/time stamped as entered precisely when the laboratory calls.

the lab flowsheet and the time the nurse was notified is 40 hours and 13 minutes. One has to ignore the test result report date/time stamp. It is difficult to adequately judge 19e because of the variety of date/time stamps that are not all accurate. The time the nurse was informed is documented in a note on 10/25/22 at 4:13 pm in a nursing note. A provider note appended to the same date/time stamped nursing note is opened at 4:13 pm but is closed at 11:05 pm. The provider took action. The time the lab result is received at the lab should be roughly a similar time to when the nurse documents in a progress note that the laboratory called. Otherwise, DPSCS will contine to have difficult verifying this item because it cannot use data from the laboratory **(19.e.i.)**. The doctor documented that other laboratory tests ordered with this test were still pending. The test results were still pending likely because of interface issues.

On the UM REVIEW tab in the 11/9/22 note at 1:11 pm, a UM alternative treatment plan is given. It is not clear what referral this relates to. It should be clear what the utilization decision is for **(22d)**.

On 11/17/22 the progress note is documented as being entered at 12:43 pm. However, at the bottom of med_chm_provider_visit progress note, there is documentation that the document was completed at 3:28 pm. It is unlikely that the patient spent three hours with the provider. I was told by providers that the medical record permits the note open for 48 hours which is a problem and will be discussed in the report **(24)**.

DPSCS does not have a system to document when the patient returned to the facility. Thus, any new recommended orders or follow up are not consistently addressed. At the 11/18/22 nephrology consultant visit, the nephrologist documented that the patient returned from vascular surgery and earlier had his ultrasound. Neither the vascular surgery consultant report, the ultrasound report nor any recommendations were available in the record **(22d)**. There was no documentation in the medical record that these events had occurred **(22d)**. At a minimum, all patients returning from an offsite appointment should be immediately seen in the dispensary for a nurse to call a provider for any new orders. Policy and procedure should be adjusted. The nephrology note was documented as occurring at 12:37 pm which appears to conflict with a provider note that was started at 12:43 and lasted until 3:28 pm. It is extremely unlikely that the nephrology evaluation took only six minutes. The time signature of notes in the electronic record do not appear accurate and should be standardized to ensure accurate documentation **(24)**.

On 11/19/22 a provider saw the patient post nephrology visit. The provider documented that the vascular surgeon recommended return to dialysis surgeon a month after vein mapping. However, the provider documented that report of the ultrasound and vascular surgery consultation were not yet available. All consultation reports need to be in the medical record **(22d)**. The physical examination section of this encounter included a long paragraph of auto-filled examination findings for the musculoskeletal system that were all normal and irrelevant to any problem of the patient. The use of auto-fill examination findings should be discontinued as it is improperly used **(18b)**. The patient was released after this evaluation.

Patient 2

This person's intake screening was evaluated. He was incarcerated on 9/25/22 at 10:03 am. There were two medical records for this person. The nurse clicked "no" for the radio button asking if he had any medical conditions but the nurse documented "yes" that he was taking medication and documented propranolol in the comment box. The medication verification form in the sallyport papers documented that the patient was on atorvastatin and propranolol. All the remaining boxes were checked "no". This was an inaccurate IMMS the patient had an unidentified medical problem and the medications were inaccurate **(17a)**.

The sally port note had two date/time stamps: 9/25/22 at 10:03 am and at 9/27/22 at 12:46 pm. Which one is correct? The IMMS was date/time stamped at 9/25/22 at 10:03 am, the same time as one of the sally port screenings. At 1:56 pm on 9/26/22 about 28 hours after the IMMS, a provider opened an intake assessment. This note was completed at 4:50 pm indicating that the note was kept open for almost three hours. This would make the assessment completed at about 31 hours. In talking with providers, I was told that providers open notes but do not have time to complete notes so they complete the note later. How is this to be judged with respect to the 24 hour time frame for completing 17b. The date/time stamp of the note, I believe, is the date/time used to judge compliance but it may only reflect a time-open but not the completion of the note. In any case, the assessment was not timely **(17b, 24)**. The provider documented hypertension, hyperlipidemia and genital herpes as problems. The blood pressure was 143/102. Propranolol and atorvastatin were ordered. Blood tests were ordered. The lab tests were not done **(19e)**[3].

Patient 3

This patient was incarcerated 10/26/21. He had hypertension, history of chronic pain, prior and osteoarthritis. The IMMS identified no deformities, no difficulty walking, and no current use of any durable medical equipment. The health assessment about seven hours later documented prior bilateral hip replacements. The patient told the provider during the health assessment that he had fallen the day before. Yet, the provider did not perform a functional assessment to assess the extent of his disability or the reason for the fall **(20b, 21a**). The examination documented "steady gait" and normal appearing extremities. The balance and gait were documented as "intact". Nor did he have a cognitive assessment despite being described as a poor historian on the IMMS **(17a, 17b).** The patient was 65 years old and early in his incarceration repeatedly asked for a list of all of his medications. The intake nurse documented he was a poor historian. The intake provider did order a low bunk.

On 12/5/21 he wrote a health request stating he had trouble remembering things from one moment to the next and was having trouble hearing. Yet the patient did not have a thorough cognitive assessment to assess for memory deficits or early dementia **(18e)**. A provider evaluated the patient on 12/7/21 for the memory loss but did not conduct a thorough neurologic evaluation including a cognitive assessment. The neurologic examination was "alert and oriented x 3. Grossly normal intellect". The patient complained at the 12/7/21 visit of chronic hip pain. A thorough neurologic examination and a functional assessment of his disability were not performed **(18b)**. But, the following day a low bunk was re-ordered along with a cane. These should have been ordered at intake. The cane was documented as being provided on 12/8/21 but on 12/17/21 the patient placed

[3] Staff who reviewed this documented pointed out if a laboratory sign off button is used one can see that the laboratory test was drawn but not presented in the electronic record.

a health request saying he hadn't received his cane **(20b, 21a)**. This sick call request was filed in the record on 12/20/21.[4]

The inmate placed a request for left arm numbness on 1/3/22 for which he was evaluated on 1/4/22. The request complained about numbness in the left arm with chest pain and wanting to know what all the medications he was taking were for. He was on 13 medications. This was understandable because of his prior stated memory issues. When seen for this request on 1/5/22, the provider documented that another provider, the day before, had explained his medications. But the shoulder was not examined nor was the left arm numbness addressed. On 1/21/22 an ADA nurse saw the patient. When the patient complained of left shoulder pain, he was told to place a sick call request.

On 1/21/21 at 5:27 pm a provider saw the patient in "neurology" clinic. The patient reported that he was unable to conduct daily chores due to his symptoms of left arm numbness. The doctor thought that the patient had a stroke and sent the patient to the emergency room to rule out stroke because the patient had left sided weakness and asymmetric facial features. The patient returned from the ER with a diagnosis of left ulnar nerve palsy but a discharge summary was not present, only an after visit summary **(18d, 22d**). Upon return at 11:58 pm on 1/21/22, a doctor noted that a CT scan of the brain was not done. The doctor documented reviewing a hospital note but a discharge summary was not present in the medical record. The doctor documented "fall risk assessed", but there was no evidence of a functional assessment of the patient (**18b**).

On 2/23/22 the patient wrote a health request stating he had requested a COVID booster five times. I could not find the vaccination order until shown by a staff member. A vaccination tab on the banner bar would be useful for staff to track vaccinations.

The patient continued to complain intermittently of hip pains, even stating in a health request on 5/16/22 that the pain made it hard to "get up and down or walk long distances. Can't stand for long periods". The day after this health request was written, on 5/17/22, the ADA nurse evaluated the patient and wrote, "Detainee has h/o chronic pain to bilateral hips and uses a cane to assist with ambulation. He is assigned and seen on bottom bunk and is able to perform ADLS without assistance. He denied having any medical concerns during this visit". The nurse wasn't effectively communicating with this patient **(21b)**.

On 5/25/22, a provider saw the patient for chronic care for hypertension, chronic back pain and seasonal allergies. The blood pressure was 149/83 which is elevated. The doctor noted that the patient had throbbing pain aggravated by standing with joint instability and numbness in the leg. The plan of care was inadequate. There were two problems lists each of which contained different problems. Some of the problems were not problems but symptoms (visual disturbance, musculoskeletal hypomobility). Some were probably not chronic problems but episodic events (constipation, tinea pedis). Some were intermittent or not chronic or not warranting chronic care follow up based on provision 18 (dermatophytosis of the nail, allergic rhinitis). Only two of the problems were included in assessments: hypertension and seasonal allergies. One of the assessments was not specifically included in the problem list: "other abnormality of gait and

[4] Staff reviewing this document stated that a provider also reported that the patient didn't receive the cane and sent an email following up on the order.

mobility". It wasn't clear what this assessment was related to. The plan was to use the cane, increase exercise, continue current medications, and follow up in three months. This patient had chronic hip pain with functional disability for over a year. The plan of care was not associated with chronic problems and did not clearly define all problems. Important problems did not include an assessment and plan. Some plans were inadequate. **(18a)** He should have been referred to an orthopedic surgeon for evaluation **(18d, 22b)** of his chronic hip pains, difficulties walking with bilateral hip replacements and falls**.** Were there issues with his prosthetic hips?

On 6/20/22 a provider saw the patient. On 12/13/21 record from the Veteran's Administration were requested; the records were never obtained. These records were requested again on 6/20/22 before a provider ordered an MRI. There was no evidence that the records were obtained **(24**). At this visit the provider noted back and leg pain that prevented him from carrying out activity of daily living and chores. Aside from noting unsteady gait a thorough neurologic examination was not conducted. The doctor appeared to auto-fill an assessment of "abnormality of gait" with an impression: "chronic, Fall risks assessed". This same phrases has appeared in other notes and seems to be an auto-filled assessment. In this case, there was no fall assessment documented in the record though a functional assessment should have been done **(21a)**.

The patient had continued back, hips, and leg pains with mobility impairment. But did not have either a functional assessment or a thorough examination. Eventually, the patient had an unwitnessed fall in the shower on 11/28/22. The doctor documented that the patient was having more frequent falls and noted that an MRI was previously ordered but "the order is not in the system at this time" **(18a, 18d)**. The patient was sent to a hospital.

The patient was discharged on 11/30/22, but there was no hospital report **(22d)**. Instead a doctor handwrote a progress note that the patient was discharged with instructions to use a wheelchair for ambulation due to multiple level spinal degenerative arthritis and weak hip joints. A MRI was done at the hospital but no results were in the record **(22d)**. On the hand-written note, the doctor documented ordering a wheelchair but no order for a wheelchair was found until three days later **(18a, 21a)**. He documented that the patient needed follow up with a specialist from UMMC in 2 weeks. The actual referral was made about five days later on 12/5/22. DPSCS should institute a system such that when a patient returns from a specialty consultation or hospitalization, they are immediately and directly brought to a designated location (dispensary or sally port) where follow up specialty care and necessary medications are promptly ordered.

At this point the patient should have had a functional assessment **(18e, 20b, 21a)**. A physical therapist did see the patient on 12/5/22 but the physical therapy notes are consolidated into a series of four PDFs and it is unclear where the initial assessment is. The patient received therapy, but DPSCS should have had the physical therapist perform a functional assessment to determine what activities the patient could reasonably perform. A structured functional assessment is lacking in DPSCS. These are typically done by physical or occupational therapist but possibly can be done by nurses. The assessment should determine the ability of the patient to perform specific tasks on a safe and dependable basis over a period of time. This would include a history, neurologic and musculoskeletal evaluation, physical effort determination and evaluation of behaviors that might impact performance.

The patient was referred to physical therapy but was only approved for three sessions. He was not referred for a functional assessment. The med_chm_consultation tab on the 12/5/22 12:33pm notes referring to physical therapy is unintelligible and it is not clear what the patient is being referred for **(22b, 24)**. The referral form is five pages that includes two other referrals and it is not clear what that patient is being referred for. This form is confusing and should be re-designed. I was told that providers had complained about this form and that it was improved. Though the author of the note is one doctor, another medical provider is mentioned on the first page which makes it unclear who is the ordering physician. This form has information extraneous to the specific referral which should be removed. The design of the form is not appropriate **(24)**.

The patient was admitted to the infirmary on 12/6/22 without ever having a functional assessment. Without such an assessment, providers and nurses did not develop an infirmary care to address the patient's disability needs. Nor was an effective provider or nursing plan of care, regarding his disability, documented in the record **(18e)**.

Patient 4

On 5/13/22 at 11:01am a nurse documented an IMMS. Nurse documented "yes" to the question whether the patient used any drugs or alcohol within last 72 hours but the substance used wasn't documented. The nurse documented that the patient was taking no medications nor had any medical conditions. Despite not having any problems the patient was referred for an urgent medical evaluation. This made one believe that the IMMS was not done appropriately and the patient just referred **(17a).** This patient had asthma, GERD, and Crohn's disease and had just been discharged from the hospital for abdominal pain and vomiting. The patient used opioids and marijuana which were unrecognized and a COWS assessment wasn't done. None of this was identified by the nurse **(17a)**.

At 5:17 pm on 5/13/22, a sally port assessment was performed. The patient was 33 years old and reported a history of asthma (resolved), GERD, and Crohn's disease. He reported use of opioids and marijuana. The provider documented that the patient was just discharged from the hospital and had been admitted for abdominal pain and nausea and vomiting. Neither the discharge diagnosis nor hospital findings were documented. A history of the patient's Crohn disease was not taken **(17b)**. The patient was discharged on ondansetron and pantoprazole. The patient was on suboxone. The patient had Crohn disease for a few years but denied "vomiting or blood in stools". The problem list not yet mapped to SNOMED included: 1) esophageal reflux, 2) facial palsy, neuropathic pain, 3) asthma, 4) L sided hearing loss, 5) opioid abuse, 6) vaccine for viral disease COVID vaccine. The facial palsy and hearing loss had not been confirmed but were listed as problems **(18a).** The weight was 125 pounds with BMI of 19. Vitals were stable. The only examination of the abdomen was "normal auscultation" despite being discharged for an acute abdominal problem and chronic Crohn disease **(17b)**. Also, the provider ordered Hepatitis C, a syphilis test, and HIV none of which were done **(17b and 18a)**. The plan for opioid use was to order COWS testing but the order could not be found in the EMR **(18f)**. If the chm_detox_monitor tab is clicked, it verifies a COWS was done but this needs to be on the progress note as it is a test performed during this encounter. It appears that one has to click every tab for every note to be certain that all information is identified **(17b)**? For Crohn's disease the provider ordered Compazine and omeprazole which were substituted for ondansetron and pantoprazole. Though these are reasonable substitutions, the provider did not document a rationale why the substitution

was made **(17e)**. A follow up was ordered in two weeks for the Crohn disease. For the GERD omeprazole was ordered. The provider ordered clonidine, ibuprofen, loperamide, omeprazole, Pepto-Bismol, and prochlorperazine. There was no evidence of the patient receiving medication because medication administration records are not present in the medical record. Now that scanning capacity has improved all medication administration records need to be scanned to the electronic record.

On 5/15/22 addiction medicine saw the patient at 12:10 pm but the note was not completed until 3:40 pm indicating the note was kept open for over three hours **(24)**. COWS were documented as ordered three times a day for five days but it appeared that they were ordered earlier. COWS testing was completed twice on 5/14, 5/15, and 5/18 and three times on 5/16 and 5/17 **(19c)**. On 5/14/22 COWS testing was to be done at 7:52 am but the nurse couldn't locate the patient. The patient did not receive medication. The nurse wrote, "Pt wasn't seen for MSW, per medication officer, he can't be located. Traffic was called and per traffic @0617 and traffic officer stated pt was here somewhere on the booking floor despite my efforts pt wasn't seen and the medication officer could no longer be located" **(17d, 20c)**.

On 5/26/22, the patient placed two health requests asking to be vaccinated for COVID. There was no evidence that the patient was vaccinated **(18c)**[5].

On 5/27/22 the patient was transferred to MTC. A transfer document documented 1) vaccine for viral disease (unclear what this meant), 2) left sided hearing loss, 3) facial palsy/ neuropathic pain, 4) esophageal reflux, 5) asthma, 6) opioid abuse. This list appeared not accurate **(18a, 18f)**. The transfer summary had a long list of every PPD ever received from 2009 including a separate table of every manufacturer's dose of PPD. Another table included labs ordered since 2009 which included ordered hepatitis C and HIV ab neither of which was in the laboratory results sheet. A third table was another table of PPDs administered since 2009. Another table was ordered specialty and provider referrals since 2014. Chronic care enrollment was also include and for this incarceration included "internal medicine". This form is not useful and these tables have clearly not been de-bugged and reviewed carefully as they are mostly not useful and should be truncated to the past year or two **(18a, 18f, 24**).

At MTC, the patient again asked to be vaccinated for COVID on 6/1/22 and said in the health request that he had requested vaccination previously but no one responded. The patient was released on 6/16/22.

He was re-incarcerated on 10/30/22 and an IMMS was done at 7:48 pm. The IMMS documented he was on no medication, was experiencing withdrawal, but was NOT on a methadone program even though previously was in a methadone program. Asthma, bronchitis, and Crohn disease were identified as problems but the patient was documented as on no medication. A peak expiratory flow rate was not obtained despite the asthma. Despite radio box information documenting that the patient was not on methadone, a comment box documented that the patient was on suboxone. There were multiple problems with this IMMS **(17a)**. An urgent referral to medical was made.

[5] Staff told me that a nurse attempted to evaluate the patient for the health request asking to be vaccinated on 5/27/22 but the patient had already transferred on that date to MTC. Nevertheless, MTC is a DPSCS facility and I cannot understand how the sick call request or the request for vaccination transmitted to MTC.

The intake assessment was done on 10/31/22. The note in the patient history tab documented that the intake assessment note was opened at 1:01 am but the note was closed at 6:52 am. This implied that this note was opened for almost 7 hours! This has a potential impact on the accuracy of 17b and the medical record **(17b, 24).** The note documented that the patient wasn't vaccinated for COVID but he wasn't offered COVID vaccination, though at a prior incarceration he asked to be vaccinated **(17b).** The history identified asthma, Crohn disease, and chronic pain. He gave history of asthma triggered by anxiety and exercise with a peak expiratory flow rate of 440. The history of Crohn disease was not good; patient said he was on Phenergan for Crohn which wasn't questioned further even though this medication is not prescribed for specifically for Crohn disease **(17b).** The patient said he was on suboxone and stated he had nausea, vomiting and diarrhea. There were two problem lists which were different from each other and both were different that the problems listed in the assessment **(17a and 18a)**. The physical examination did not include evaluation of opioid withdrawal signs **(17b)**. Five assessments were made: 1) Crohn disease (referred to chronic clinic) 2) opioid dependence (referred to addiction medicine) 3) asthma (prescribed albuterol inhaler and referral to chronic care) 4) chronic pain (continued Tylenol). Orders were made for labs including CBC, CMP, hep C and HIV. None of these labs were completed **(17b, 19e)** but the order was present in the order section. A better history of asthma and Crohn disease should have been obtained. It is possible that the patient did not have these as active diseases and old records should probably have been obtained to verify his problems **(18f)**. COWS tests were ordered TID for five days with referral to addiction medicine. The order for COWS was not found **(17b)** in the order summary.

Addiction medicine saw patient at 9:40 am on 10/31/22 and verified on CRISP as being on suboxone 12 mg with the last fill on 10/28/22. The problem list was 1) "nausea and vomiting". A 2nd problem list not yet mapped to SNOMED included: 1)esophageal reflux, 2) facial palsy/neuropathic pain, 3) asthma, 4) L sided hearing loss, 5) opioid abuse, 6) vaccine for viral disease. These problem lists were different and not mapped to the assessments and should be debugged **(18a)**. There is a section called “completed-orders-this-visit” that does not include any orders. These included the following comments: 1) continue current medication, 2)reviewed medication, 3) stop current medication, 4) take new medication, 5) increase fluid intake, 6) increase activity level, 6) discussed risk/benefits/side effects of treatment, 7) discussed non-compliance medications, 8) patient was reassured, 9)follow exercise program, 10) sick call PRN, 11) patient education provided and patient voiced understanding. This list of auto-filled items is meaningless and is detrimental to an honest and accurate medical record. These auto-filled statements should be reconsidered. Did the doctor actually discuss following an exercise program; the exercise program was nowhere documented in the progress note. Assessments for this patient included 1) opioid abuse and 2) marijuana dependence. The patient was started on methadone. This note was started at 9:40 am but not completed until 12:04 pm. This date/time stamp should be modified.

On 11/1/22 at 4:59 am a physician assistant wrote a note but the note was completed at 9:53 am, about five hours later. Did the patient evaluation take five hours? If not what part of the note was written from memory? This practice should be reconsidered **(24)**. The PA wrote that the patient said he was vomiting with abdominal cramps. The patient said he did not receive ordered methadone that day **(19a 19b)**. The patient then received methadone and returned to the sally port.

Apparently he was housed in the sally port where he was not been receiving COWS testing **(19c)** or medication.

On 11/2/22 at 4:23 am a nurse entered a note that the patient had a coffee ground emesis and was to be escorted to the sally port. The patient was sent to an ER.

At 2:30 pm the patient returned from the hospital with diagnosis of acute gastritis. The nurse referred the patient to a physician for "clearance". The doctor documented that the discharge summary was reviewed but there was no hospital report scanned to the record **(22d)**. On 11/3/22 the patient was released from jail.

Patient 5

This patient is listed as "deceased" on the banner bar **(24)**. This patient had three medical record that were not unified **(24)**. The IMMS was completed on 11/2/22 at 6 pm for a 32 year old man. Nurse identified Crohn disease with colostomy bag and heroin abuse. The colostomy bag arrangement was not inspected **(17a)**. Remarkably, though the patient had serious Crohn disease, the nurse identified no medication. The nurse referred the patient urgently to a provider. The nurse did not identify whether colostomy bags were ordered for the patient. A provider ordered colostomy care at 10:33 am on 11/3/22 and someone re-ordered care at 12:04 pm. Care was provided on 11/4/22 at 7:03 am.

A nurse practitioner saw patient on 11/3/22 at 10:09 am for a health assessment noting bipolar disorder, opioid addiction, and Crohn disease as problems. An ileostomy was done in 2020 but the nurse practitioner did not say why the ileostomy was not reversed and did not determine when it needed to be reversed. There was no history of Crohn disease nor its treatment, nor why the patient had an ileostomy. This was an inadequate history **(17b, 18a).** Chronic conditions "addressed today" documented inflammatory bowel disease and problem list documented ileostomy. NP documented abdominal symptoms of pain, diarrhea, and nausea. The abdomen wasn't examined except to note that the patient had an ileostomy draining liquid stool in the ileostomy bag. If there was liquid in the ostomy bag, this was a concern but was not addressed. This was not an adequate examination or evaluation **(17b)**. A section titled "Completed Orders (This Visit)" auto-populated with items including the statements continue current medications, take new medications as ordered, increase fluid intake, and clean and dress wound daily, increase activity level, discussed risk/benefits/side effects of treatment, "patient was reassured", follow exercise program even though many of these statements were not pertinent to the patient's plan of care. These Completed Orders should be eliminated as an auto-populated item. If a provider wants to state these were done the provider should document them **(18a)**. The provider ordered the colostomy supplies. Assessments and plans included 1) Mental disorder even though a mental health diagnosis was not present **(18a);** 2) opioid disorder (with a plan to order COWS for four days with referral to addiction medicine; 4) colonic inflammatory bowel disease with a plan to refer to chronic care. Given that the patient had "liquid stool", a sample should have been obtained to test for blood. Also, given the history of Crohn with ileostomy a CBC, CMP, CRP and sed rate were indicated (given the liquid stool and uncertain status of his inflammatory bowel disease) **(17b, 18a);** 5) ileostomy without a plan for reversal **(17b, 18a)**. Colostomy care was ordered daily.

Hepatitis C was ordered. This lab was ordered but apparently the test was never done[6] **(17b, 19e, 24)**.

On 11/4/22 at 9:34 am, a provider saw the patient urgently for abdominal pain and perianal pain. The provider noted that the patient had a peri-anal fistula with tube drainage. Notably, this wasn't picked up on the health assessment or IMMS **(17a, 17b)**. He had severe abdominal pain and complained of weight loss, nausea, and vomiting for past 24 hours. There was pus draining from the tube since 2020 and patient had not had follow up for more than two years with a surgeon where colostomy was done. The patient was sent to the hospital but there was no documentation in the record at what time the patient left the facility for the hospital **(18d)**. At the hospital a perianal abscess was found extending into the scrotum with high ileostomy output. Follow up gastroenterology and general surgery were recommended.

Upon return from the hospital on 11/18/22, the patient was admitted to the infirmary at MTC. The hospital summary was reviewed. The nurse practitioner did not order the referrals but the referrals were ordered the following day by a physician**.** The problem list included 1) perianal abscess, 2) Crohn disease, 3) scrotal swelling and 4) colostomy. There was no examination of the rectum nor of the abdomen **(18b)**. The assessments were Crohn disease and colostomy. The assessment and plan did not include all of the problems **(18a)**. The plan of care was to admit to the infirmary, "sick call as needed", regular diet, acetaminophen, Augmentin, Creon TID, multivitamins, Imodium, Lomotil, melatonin, Metamucil, and protonix. Baseline labs were not ordered; nor were labs from the hospital noted **(18a)**. The progress note on 11/18/22 documented that the patient needed referrals to GI and general surgery in the history but these were not scheduled **(18d, 22b)**. Though the patient was admitted to the infirmary, there was no order for colostomy care nor for the abscess **(18a)**. It wasn't clear whether there was a drain. There was no medication ordered for Crohn disease and it wasn't clear whether the activity of the disease was known. The provider should have reviewed the hospital summary to determine the recommended treatment plan . The plan of care was inadequate **(18a)**.

Two referrals were completed; one on 11/19/22 at 10:17 am and another on 11/19/22 at 10:35 am. The 10:17 referral form appeared to be for gastroenterology but four apparent past referrals were included which made it difficult to determine the purpose of the current referral. There is considerable irrelevant information on the form and three duplicated histories. A utilization management section on the form is incomprehensible. This form needs redesign to be simplified and truncated **(24)**.

The consultation form with the time10:35 am appeared to be for general surgery but also included the prior four referrals. It was not clear what the purpose of the current referral was. The urgency of the referral was not apparent. There was much irrelevant information and the paragraph of history was repeated five times. The utilization management information was incomprehensible. The consultation request was six pages of mostly irrelevant or repetitive information that could easily be truncated to a half page which would be concise and crisp (**24),** The consultation was recommended at the hospital for two weeks which would be an urgent consultation but it was not

[6] In reviewing this with staff, I was shown that the lab test was ordered. The phlebotomist wrote in a sign off location that the patient was released when he was not released. This is evidence of a software bug in the electronic record, a failure of the alpha list or a defect in the phlebotomy process.

clear whether it was referred urgently **(22b)**. The current referral practice is not apparently standardized and is not explained in the procedure of the DPSCS policy **(22a)**. I could not find a utilization review for either of these referrals nor could these consultation be found on the specialty tracking log **(22a, 22b, 22c, 22d).** The requested timeframes for both consultations was not provided **(22b, 22c, 22d)**.

On 11/20/22, at 1:52 pm a nurse note documented under "subjective" that the patient said he needed tape to hold the bag. There was no nursing plan of care for his colostomy care, wounds, or abscess. In general, the infirmary nursing notes do not include a nursing plan of care nor is there evidence of physician orders or collaboration on development of the nursing plan of care **(18a)**. Care of the colostomy appears to be left up to the patient as nurse documented, "he changed his ileostomy bag". A nurse said in the 11/20/22 note, "will continue with the plan of care" but there is no evidence that there is a nursing plan of care. The nursing notes on the infirmary have not been designed well. There is no plan of care related to the needs of the patient. The nursing notes include multiple dated notes from prior dates and it is unclear what the purpose of these notes are. The nursing plan of care as documented in the medical record needs considerable work **(18a, 24)**.

The physician infirmary rounds on 11/20/22 included no new history except “no complaints”. There was no examination. The only assessment was chronic inflammatory bowel disease with no stated plan. It wasn't clear when the consultations would occur. The plan of care was not clearly documented and had to be inferred. There was no investigation as to the referrals, no laboratory tests were ordered, there was no documented care of the ostomy or the drain, and follow up with the surgeon and GI were not established **(18b, 22a).**

On 11/21/22 at 11:19 pm a doctor wrote a progress note that did not document, in the plan of care, what the plan was with respect to the referrals to the general surgeon or gastroenterologist **(18d)**. Subsequent to the 11:19 pm progress note, which did not document a plan for the gastroenterology and general surgery referrals, the provider apparently attempted to refer the patient to gastroenterology and general surgery. There were two referrals: a gastroenterology referral created at 11:19 pm and a general surgery referral created at 11:36 pm. The format of these referrals was dramatically different from the referrals from two days earlier which implies that the forms used for referral are not standardized and the referrals can be optionally chosen by the referring provider. Both forms were a single identical brief paragraph; one referring the patient to gastroenterology as soon as possible (in one week) and the second referring the patient to general surgery as soon as possible (in 2 weeks). There was no utilization note associated with either referral I could find **(22d)**. Neither referral was not found on the utilization log **(22c).** There was no evidence that utilization review occurred for either referral **(22b)**. The medical record lacks a quick-view snapshot of pending consultations **(18d, 22d, 24)**. The procedure in DPSCS policy was developed years before the current process was initiated and the policy and procedure should be revised (22a). It also appeared that because two very different ways to order a referral were used by two different physicians that the procedure is not yet clear or training on use of the form in the updated medical record was ineffective **(22a, 24).** The consultation process in the electronic record is a mess and is a significant barrier to obtaining access to necessary care for inmates.

An example of the nursing plan of care was seen in a nursing note on 11/22/22 at 4:54 am. The plan of care was not documented. The note starts with identification of allergies, vital signs (patient

refused), and comments. There was no history. The objective examination included a number of observation for "skin/musculoskeletal" specifically pink/warm, moves extremities, full spontaneous, independent bed mobility, steady gait, absence of swelling. These observations had nothing to do with the patient's condition and its purpose was unclear. The next set of nursing observations was "neurological" and documented that the patient was oriented to place, person, and time and had clear speech and motor response. This went on through cardiovascular, pulmonary, GI, GU. For GI nothing was recorded but the patient was admitted to the infirmary for Crohn disease and a rectal abscess. Despite all of its documentation, the nursing plan for the patient's needs (drain, wound, abscess, and ileostomy) was not clear in this note. At the end of the note in the comment section the nurse documented that ostomy care was continued and that there was no leaking or bleeding. The nurse documented notifying a doctor about an acetaminophen allergy. The note did not reveal what the plan of care for the patient was related to specialty care, medicines, changes for which to notify providers, etc. This pre-formatted note was not designed to address the needs of the patient **(18b, 24)**.

The patient appeared to be released around 12/1/22. Neither of his specialty appointments were scheduled despite multiple attempts to refer the patient. The utilization system continues to be a barrier to access to specialty care **(22b)**.

Patient 6

On 12/27/22 the patient was apparently rejected and sent to the hospital. There was no rejection note. There was no discharge summary from Johns Hopkins Hospital for hyperglycemia. Only an after visit summary was included. The patient was given acetaminophen, gabapentin, aspart insulin (dose not specified), nifedipine XL twice with recommendations for internal medicine follow up. There was a recommendation to continue glargine insulin 20 units nightly. There was no discharge summary that described what occurred at the hospital nor were recommendations provided except to continue insulin **(22d).**

On 12/28/22 an IMMS was completed at 1:30 pm. The IMMS documented a 50 year old man with history of diabetes, hypertension and mental illness and had drug and alcohol abuse. COWS and CIWA with IMMS were 3. A random sugar was 213. BP was 145/56. The nurse clicked the radio button "no" for medication but did write that the patient was on suboxone in the question on methadone **(17a)**. A nurse clicked "Yes" to the radio button that the patient had medical problems but these were listed above in a comment box. The patient's disability was unrecognized **(17a)**. An urgent referral to medical was ordered. The nurse documented in a comment that the patient was at Johns Hopkins for hyperglycemia. The IMMS does not have space to document whether the nurse called for a medication order nor whether the nurse provided or called for an order to provide prompt medication or ADA needs. This should be done. DPSCS told me that there is procedure in place to place a colored band on persons who need early attention. In this case, the patient was given insulin at the hospital at 7:50 am on 12/28/22. The patient had his IMMS at 1:30 pm on 12/28/22 when the blood sugar was 213. No insulin was documented as ordered at that time. The patient did not see a provider until 8:49 pm. At 8:49 pm (about 14 hours after last insulin at the hospital and 7.5 hours after the IMMS) when the provider saw the patient the blood sugar was 482. Insulin was ordered then but was not documented as given until 11:27 pm (about 18 hours after the last insulin) and the blood sugar was 440. Only 6 units of regular insulin was given. The ordered Lantus insulin was not given until the following day at 7:10 pm. Though the

provider ordered 5 units of regular insulin with meals for blood sugars between 200 to 350, the blood sugar was not documented as checked at breakfast or lunch on the 11/29/22. There was no medication administration record in the electronic record. DPSCS should review their procedure to ensure that for persons on insulin or other critical medications, that prompt orders and administration of medications can be provided. Patients on insulin or other critical medications (insulin, rejection medication, clopidogrel for stents, etc.) should see a provider immediately after identification of one of these critical medications by a nurse. **(17a)**.

On 12/28/22 at 8:49 pm, about 7 and a half hours later, a physician assistant documented a health assessment. The PA documented a history of hypertension, diabetes, hepatitis C, chronic pain, opioid, benzodiazepine and alcohol dependence, and mental illness. The PA documented that no discharge prescriptions were included. The patient was homeless and didn't remember his hypertension medications but remembered that he took Lantus and regular insulin. He couldn't remember his last hemoglobin A1c. The patient was in a suboxone treatment program and took 8 mg suboxone. The problem list not mapped to SNOMED was 1) opioid abuse, 2) hepatitis C, 3) polyneuropathy of diabetes, 4) type 2 diabetes, 5) hypertension, and 6) vaccine for viral disease COVID yet there was no evidence of receiving COVID vaccine. The problem list did not match assessments **(18a)**. The blood pressure was 134/90, the capillary blood glucose was not retested even though the patient had been in intake presumably without insulin for over eight hours **(18a)**. An immunization table present embedded in the intake assessment note did not make sense. It repeatedly documented flu vaccine being given 8 times all on 11/14/16 and pneumovax being given 6 times all on 1/13/17. It wasn't clear what this meant. Did it mean that patients actually received vaccination or something else? This table appears to be a bug and should be fixed **(24)**. The examination for this patient did not include an examination of the feet except for pulses and no evaluation for neuropathy although the patient had a diagnosis of diabetic neuropathy on the problem list **(18b)**. Problems with the assessment and plan included:

- For diabetes there was no evidence of having received any insulin in the sally port and the blood sugar rose to 428 and the PA ordered Lantus 20 units HS and 5 units TID with meals if the FS was 200-350. An immediate administration of some insulin was indicated as the patient had not received insulin since incarceration. During the IMMS, nurses should alert providers to diabetics and their insulin regimen so insulin orders can be timely **(17d, 18a, and 19a).**
- The assessment of chronic pain in the left foot was assessed without adequate history or physical examination. The plan was for Naprosyn and Robaxin and "pain management" clinic but the patient had a gait abnormality with amputated toes for which there was no physical examination **(17b, 18a, 18b)**.
- The assessment of abnormality of gait was made on a brief history of partial amputation of his toes with gait abnormality for which he used a wheelchair which he did not have with him. The plan was an ADA referral, and a walker and low bunk. There was no physical examination except to visually note the amputations. Nor was there a functional assessment to determine what activities the patient could accomplish **(18a, 20b, 21a).** A walker was ordered for the patient but his needs were not established.
- Multiple lab tests were ordered (CBC, CMP, lipid screen, RPR, TSH, A1c, microalbumin, hep C RNA with quantitative) but the lab results flowsheet did not have the completed labs **(19e).**

Patient 7

For this patient, the sally port screening was documented as occurred on 1/30/23 at 6:01 am. However, the sally port paperwork includes a hand-written order physician order sheet dated 1/28/23 at 6 pm for COWS testing three times a day with medication orders for detoxification. The sally port paperwork also included a hand-written COWS form filled out on 1/29/23 but not timed. This indicates that the patient was in the sally port at least as early as 1/28/23 but the sally port evaluation was documented in the medical record at 1/30/23 (24). An IMMS had not yet been done. On 1/31/23 at 5:18 am, three days after the first medical document in the jail, a physician assistant evaluated the patient emergently on the 3N unit for acting bizarre. He was sitting on the floor with a complaint of shortness of breath. He was 54 years old. It was reported he took fentanyl but the patient denied this. He was given Narcan and sent to the hospital.

The patient returned from the hospital on 1/31/23 at 11:54 am the same morning. There was no discharge summary only an after visit summary which did not have medical information on it. The patient was evaluated by an addiction medicine provider at 2:35 pm on 1/31/23.

On 2/1/23 at 11:39 am, an IMMS was done, four days after incarceration **(17a)**. The IMMS documented "no" to all questions except he used drugs and was experiencing withdrawal. The nurse referred the patient to an advanced practice provider but no other action was taken. The nurse did not document in the IMMS that the patient had been sent to the hospital nor what occurred at the hospital **(17a)**. The IMMS did not accurately record recent events nor was it timely. The intake assessment was completed on 2/1/23 at 3:59 pm but was not labeled as an intake assessment in the patient history section. He was evaluated on the 4N unit indicating that the patient apparently was sent directly to 4N after return from the hospital. The note did not document the hospitalization for or what occurred at the hospital. What occurred in this sequence of events is unclear. It appears that the initial IMMS was not done and the patient was transferred to a housing before being recognized as acutely ill requiring hospitalization.

Patient 8

This patient had two medical records but neither contained an IMMS. On 11/7/22 sally port paperwork documented that the patient was on diabetic medication as well as medication for schizophrenia.

On 11/8/22 a mental health professional documented that the patient was previously on the IMHU and was transferred to Spring Grove State Hospital on 11/3/22 and was returning to BCBIC on 11/7/22. The patient was cleared for general population.

On 11/8/22 at 1:13pm an initial health assessment was done. The provider documented hypertension and type 2 diabetes. The patient also reported schizophrenia. The patient was a smoker and used alcohol. Diabetes diagnosed five years ago and on metformin 500 mg daily. CBG was 188. The patient apparently received metformin during the encounter. This was the first documentation of receipt of medication. A1c was ordered. HTN also diagnosed five years ago but patient didn't know what medication he was taking. The patient was missing his upper and lower dentures. There were two problem lists. One included diabetes and hypertension. The 2nd "not yet mapped to SNOMED" included hypertension, multiple wounds, pre-DM, tinea pedis, abnormal glucose and multiple injuries. The BP was 120/94 and the BMI was 41 which is morbid

obesity. The weight was 355 pounds. There was no evaluation of the wounds documented on the problem list **(17b, 18b).** The examination appeared auto-filled but did not include a foot examination **(17b, 18b)**. There were two problems in the assessment: hypertension and diabetes. For the diabetes, the plan was to continue metformin, check a A1c level, CBDC, CMP, hep C AB, and to check glucose at breakfast. For the HTN, the plan was to start HCTZ and losartan and to follow up in chronic care. The laboratory tests were not found in the "Results" tab **(19e)**. The first labs were done on 1/13/23, 65 days later **(17b, 18a)**. These were apparently unrelated to the intake labs. The ten year cardiovascular risk was 37% and a high intensity statin should have been prescribed **(18a)**. The provider referred the patient to mental health but the patient had already seen mental health.

Although the provider ordered glucose to be checked before breakfast, the glucose was checked once on 11/10/22 at 6:54 am and was 124, it was not regularly checked. It was checked 21 times from 11/8/22 to 12/5/22, a 26 day time period (81% of the time) **(19c)**.

Patient 9

This patient was documented as deceased on the electronic banner bar when he was not deceased **(24)**. The IMMS was completed on 12/28/22 at 1:30 pm. The patient was just at Johns Hopkins for poor glycemic control. There was no discharge summary only an after-visit summary which gave little information. The nurse documented blood pressure of 145/56 with a blood sugar of 213. The nurse documented he had slurred speech and was unable to sit still and was "inconsistent with information. COWS and CIWA were both 3. The nurse documented diabetes, hypertension, mental illness, and drug and alcohol abuse. The nurse failed to identify hepatitis C and a significant prior foot injury with amputation requiring a wheelchair for mobility **(17a, 20b, 21a).** The nurse answered "no" to the question whether the patient was taking medication even though the after-visit summary documented that the patient was given Tylenol, gabapentin, aspart insulin, and nifedipine at the hospital **(17a)**. The nurse documented that the patient was in a suboxone program. The nurse referred urgently to a provider.

About seven hours later at 8:49 pm a provider performed an intake assessment. The provider documented homelessness, diabetes, HTN, hepatitis C, drug abuse (anxiolytic, alcohol and opioids), mental illness and an unspecified gait abnormality. The patient had a partially amputated foot and used a wheelchair; the amputation was due to a 6 year old injury. The provider did not ask about prior diabetic foot; the patient was 51 years old. The patient received NovoLog insulin, gabapentin, and nifedipine at the hospital. He didn't know his hypertensive medication but did apparently tell the doctor that he took Lantus and NovoLog insulin. The problem list included opioid abuse, hepatitis C, polyneuropathy secondary to diabetes, DM, HTN and vaccine for viral disease but it wasn't clear if the patient was vaccinated for COVID. The blood pressure was 134/90 and BMI was 19.48. The physical examination did not include an examination of the feet (except to document a normal dorsal pedis pulse) despite the amputation. The COWS was 5 and CIWA 7. The vaccination history was duplicative and recorded 8 episodes of being vaccinated for influenza on 11/14/16 and 6 episodes of being vaccinated for pneumovax on 1/13/17. COVID vaccination was NOT documented. This vaccination history is a good idea, if it results in vaccination updates, but the table as constructed is not useful or helpful with respect to identification of vaccination status **(18a).** There were 9 assessments with the following problems.

- For diabetes, the patient had blood sugar of 482 which is higher than at IMMS. Lantus 20 at night was started and 5 units of regular TID with meals if BS 200-350 was ordered but this did not provide immediate relief of a high blood sugar. Managing insulin in the sally port is not effective **(17b, 17d, 18a)**.
- For the chronic pain in amputated foot and abnormalities of gait the plan was to give the patient a walker, and order a bottom bunk. There was no functional assessment with respect to the patient's capacity to manage activities of daily living with a walker alone.
- Blood tests (hep C RNA and quant, A1c, microalbumin, CBC, CMP, HIV, and lipid screen) were ordered, but the "results" section did not show completed lab tests **(19e).**

This patient was in the sally port for about seven hours without evidence of receiving an accommodation for his disability **(20b, 21a)**.

Patient 10

This 31 year old male was incarcerated 12/29/22. The nurse answered "no" to all questions except whether the patient appeared intoxicated and whether the patient used drugs in the last 72 hours. The patient was referred urgently to a provider.

On 12/29/22 at 5:03 pm the intake assessment was done. The patient used opioids and had a COWS of 8. The problem list documented asthma, but no history of asthma was taken. The examination included no examination for signs of withdrawal. The plan of care was to treat with clonidine, ibuprofen, promethazine and Pepto-Bismol for withdrawal and refer to addiction medicine. A mental health disorder was in the assessment. The history documented "He denies history of HTN, Diabetes, Hepatitis, HIV, seizure, or any other medical or mental health condition". Yet the problem list documented asthma as a problem **(18a)**. If asthma is not a problem, it should be removed from the list. If it is a problem, it should have been addressed.
On 1/5/23, he was evaluated in walk in clinic for a finger infection. The plan of care for this new episodic problem was to start an antibiotic, give a tetanus shot, x-ray the finger, start Tylenol, and to follow up in two days. The x-ray was reported on 1/7/23. A tetanus vaccine was given on 1/6/23. However, the two day follow up evaluation did not occur. Five days later, a nurse emergently evaluated the patient because "my hand feels like it's in my bone". The nurse referred to a provider who noted swelling of the right hand and sent the patient to a hospital where the patient was admitted and treated for an abscess of the right hand. If the follow up evaluation had occurred, the hospital may have been preventable **(18c).**

Patient 11

On 1/18/23 at 12:09 pm an IMMS was done. The blood pressure was 187/99. The temperature was recorded as 88.2 degrees Fahrenheit. This is consistent with moderate hypothermia and typically associated with altered mental status and needs emergent care. This was likely an error of data entry. The nurse documented that the patient was tearful. The nurse noted that the patient was rebooked under another bin but the patient had been just discharged from the hospital and the nurse provided no explanation of what occurred at the hospital **(17a)**. The nurse answered "yes" to the questions are you in pain (a comment at the bottom of the form documented the patient was

given Tylenol at the hospital for a corn on his foot) and "are you currently taking medication". The nurse documented that the patient said he didn't know his meds but hasn't taken them for a long time. The nurse documented "no" to the question are you taking drugs and to the question "do you have a medical problem" which was remarkable as the patient was just sent to the hospital for hypertension. The nurse ordered an urgent referral and documented in a comment box that an NP was called about the current blood pressure and hydralazine 25 mg was given. This medication could not be found in the medication module as ordered on that day; it was started on 1/24/23 **(17d, 19a)**. Notably, the January MAR in the record documented that the patient received one dose of hydralazine on 1/18/23 at 6:10 pm which was about six hours after the order in the IMMS which was not found officially in the electronic medical record. It appears that this MAR captured the physician order at 4:51 pm for another stat dose of hydralazine.

On 1/18/23 at 4:51 pm a provider completed an assessment. The history for this 57 year old was that he had a past history of HTN, and cocaine abuse. He was documented as not taking medication as a civilian for three years. On booking he was sent to the emergency room due to BP 227/131 "last night" and treated with Procardia and had BP 188/106 and was given hydralazine. The problem list was only hypertension. The provider did not verify that the patient had received any medication but documented that hydralazine was given based on patient history. BP was 188/103 at the assessment. The assessments were hypertension and alcohol abuse with withdrawal. The plan was to start Norvasc 5 mg, give one dose of hydralazine, follow up in a week in "cardiology" clinic. For the alcohol problem, CIWA monitor for an unspecified amount was ordered and he was started on Librium tapering dose over four days with thiamine. The hydralazine was given at shortly after 6 pm along with the first dose of Librium and the thiamine. The Norvasc was not started. CMP, A1c, CBC, Hep C, Lipid screening labs were ordered and appear in the record as ordered in the order summary but were never done **(19e).**

On 1/19/23 a medication nurse documented that the blood pressure was high and referred the patient to the sally port for a blood pressure of 207/142. There was no evidence that the patient was receiving medication because the medication administration record is not available in the electronic record **(24)** and the practitioner did not comment on whether the patient had received medication. At some point the patient was sent to the hospital but there was no transfer out document in the medical record nor is there a transfer back document, so it is unclear when the patient went to the hospital **(22d)**.

There was no discharge summary from the hospital **(22d)** but there was an after visit summary. Some labs and an abdominal CT scan were included. The diagnoses were provided and identified HIV infection and renovascular hypertension.

On 1/20/23 at 11:54 am a provider hospital return note documented that the patient just returned from the hospital and was being admitted to the infirmary. The doctor failed to document that the patient had HIV infection. The problem list only contained hypertension as a problem. Two assessments were made: hypertension and dehydration. Norvasc was increased to 10 mg but there was no evidence that the patient ever received this medication. There was no referral to an HIV specialist for evaluation for medication nor was there a viral load or T cell count to help assist in treatment.

The HIV infection was identified on 1/23/23 but the doctor diagnosed it as "stable". The hospital had given a diagnosis of symptomatic HIV infection. The doctor did not order viral load or CD4 count and did not promptly refer to an HIV specialist to start medication. The hepatitis C was assessed as stable but viral load and fibroscan were not ordered. Nor was the patient referred to an HIV specialist to treat the hepatitis C which is more problematic in persons with HIV and for whom treatment is recommended **(18d)**. The patient was released later that day.

The patient was re-booked the same day and the nurse answered "no" to the questions are you on medication and do you have medical problems. The blood pressure was 184/114. The nurse failed to document all that had occurred over the past couple weeks, including the diagnosis of HIV and hepatitis C (**17a)**. A provider completed an initial health assessment on 1/24/23. The PA documented that the patient was recently incarcerated and was on the infirmary for uncontrolled blood pressure and dehydration. He documented that the patient was very weak and unable to ambulate on his own without assistance. This was not identified by nursing during IMMS, nor was it identified by provider during the prior infirmary admission. The patient was too weak to use a walker and the PA admitted the patient to the infirmary. The patient was unable to stand on the scale for a weight. The blood pressure was 168/98. The assessments included 1) alcohol abuse- continue folate and thiamine; 2) HIV infection, the only plan was referral to chronic care. His prior treatment history should have been obtained, 3) HTN, 10 mg Norvasc was continued, 4) weakness- admit to infirmary. HIV viral load was ordered but T4 count should also have been ordered and a prompt referral to an HIV specialist should have been made **(18a)**.

The patient was admitted to the infirmary on 1/25/23. The first provider note on 1/25/23 documented a history of hypertension, substance abuse, HIV and hepatitis C. There was no further history regarding his HIV infection except that the patient was noncompliant with antiretroviral therapy. There was no physical examination. The assessment included HIV infection, hypertension, alcohol abuse, and hepatitis C. There was no plan for any of these conditions. **(18a)**

The patient was discharged on 1/26/23.

Patient 12

This patient had two medical records **(24)**. He was incarcerated on 3/9/22 as a direct intake from Life Bridge Health Care. The nurse documented that the patient was acting violently and exhibited difficulty moving. He was documented as having a seizure disorder in the comment box and in the question about medical problems. No other problems were identified. He had just been released about two months previous and was being treated for hypertension, epilepsy, asthma, irritable bowel, and a gait abnormality. The nurse failed to identify everything except the seizure disorder. Nor did the nurse identify medications from the last incarceration **(17a)**. He was referred to a provider but there was no identification of a mobility disorder and no accommodation made for the patient **(20b, 21a)**.

The health assessment was on 3/9/22 at 9:28 am. The provider apparently reviewed the old record and identified asthma, hypertension, epilepsy, opioid abuse and irritable bowel syndrome. A peak expiratory flow was not done **(18b)**. A low bunk was ordered for the epilepsy but there was no

functional assessment or evaluation of the gait abnormality nor was there a plan for it **(18a, 20b, 21a).**

An internal medicine chronic clinic was completed on 3/10/22 and the patient requested a cane for abnormal gait which was not identified at intake. The cane was ordered 3/10/22 but it was unclear when the patient received the cane **(20b, 21a)**. Physical examination was documented "unsteady gait" and amputated toes. The reason for the amputation was not identified **(18b)**. Because of his gait abnormality a functional assessment should have been done but was not **(18b, 20b, 21a)**. Unclear when patient received cane.

On 1/4/23 the patient was referred by an ADA nurse because the patient wanted a wheelchair. The provider documented unsteady gait and the patient had a fall a few months ago in the shower. The patient complained that he previously used a walker but trips on it. The provider documented that the patient was a high risk for falls due to unsteady gait. The doctor ordered a wheelchair. This patient should have had a functional assessment by a physical therapist to determine his fall risk, and his disability status. How capable was the patient in conducting activities of daily living **(18d, 20b, 21a**)?

Patient 13

The IMMS was on 10/21/22 at 8:15 pm. The nurse answered “no” to question 4 "Does offender have observable deformities or exhibit difficulty of movement". The nurse answered “no” to the questions whether the patient had medical problems or was on medications. In a comment box though, the nurse documented that the patient had AIDS **(17a)**.

The health assessment was on 10/22/22 at 1:07 am. The practitioner identified alcohol use, pancreatitis, bipolar disorder, hypertension, HIV infection, hepatitis C, depression, and schizoaffective disorder. Epilepsy and glaucoma were also on the problem list but not addressed by the provider. The physical examination did not examine for stigmata of HIV infection (lymph nodes, thrush, etc.) **(17b, 18b)**. The assessments did not match the problems identified, including hepatitis C, hypertension, pancreatitis, epilepsy and glaucoma for which there was no plan **(17b, 18a)**. Appropriate labs were ordered and done. A bottom bunk was ordered for his alcoholism. The patient was referred for HIV care but not for hepatitis C care. Hepatitis C is more complicated in persons with HIV and treatment is recommended **(17b, 18a).**

The patient’s HIV medications were not identified until the patient went to a chronic clinic on 10/24/22. The provider documented that the patient used a cane at home due to leg damage and surgeries. On examination the patient had unsteady gait. A bottom bunk and a cane were prescribe to prevent falls. This was not identified but should have been identified at intake **(17b, 20b, 21a)**.

The patient requested and was given a walker on 11/4/22 and eventually escalated to a wheelchair. I could not locate the original order for the wheelchair but it was renewed on 1/10/23. Despite the progression of accommodations there was no functional assessment by a physical therapist to clarify his disability and status with respect to activities of daily living. This should be done **(18d).**

Patient 14

This patient was documented as deceased on the banner bar of the medical record **(24)**. He was 34 years old. On 7/23/22 at 5:08 am, a nurse completed an IMMS and answered all questions "no". The patient did give a history of a prior ankle fracture. The patient was referred urgently to a provider. The IMMS was problematic because at the initial assessment the patient described prior open surgery to fix a lower leg fracture and that he used a cane and wheelchair for ambulation. This was not identified by the nurse and his accommodation was not initiated **(17a, 20b, 21a)**.

The initial health assessment 7/23/22 at 2:32 pm. The provider documented prior surgery to repair a lower leg fracture. The patient told the provider he used a cane and wheelchair for ambulation. He was noted to be limping. No physical examination of his legs was documented except to note pain in bilateral ankles. A functional assessment of his mobility issues was not accomplished. The problem list documented bipolar disorder and chronic pain. The provider ordered gabapentin on a sliding scale for his chronic pain but did order an accommodation (cane or wheelchair) or perform a functional assessment; nor was physical therapy ordered to complete a functional assessment to determine the status of his disability **(17b, 18a, 20b, 21a).** Most cases of functional assessment can be by the provider in the clinic. Patients should be asked if they have ever or recently fallen. Examination should include observing the gait for whether the heels clear the floor, whether there gait is symmetric without swaying and whether path deviation does not occur. Gait speed should be noted as extremely slow gaits indicate abnormality and greater risk for falls. Balance can be tested having the patient stand with feet in tandem, semi-tandem, and side by side; testing patient's stability during a 360 turn; and testing muscle strength of all extremities. For the few elderly patients with any memory problems or with significant disability, referral should be made to a physical therapist or occupational therapist who can perform a thorough functional evaluation of activities of daily living.

Three days later in a chronic clinic, a doctor ordered a cane after taking a history of a gunshot wound to his spine and fracture injuries to his foot. An examination was not done to determine the degree of disability; nor was a functional assessment ordered. A cane and bottom bunk were ordered. The basis was that the patient had pain in the left foot and walked with an abnormal gait. The cane wasn't documented as provided to the patient until 8/4/22 **(20b, 21a)**.

The patient had continued pain from his injuries. On 8/12/22 old records were requested to evaluate his prior treatment.

The patient was released on 8/26/22. On 1/30/23 the patient was re-incarcerated. The IMMS on 1/30/22 at 4:12 pm identified that the patient had nerve injury to his left leg and used a cane. The nurse documented the patient was in pain and took gabapentin and lithium and had a medical problem (nerve injury). The patient was referred to a provider urgently but an accommodation was not provided or ordered.

A health assessment was initiated at 8:12 pm on 1/31/23, 16 hours later. The provider obtained a history of his injuries and that he used a cane at home. The examination was auto-filled but identified "unsteady gait" but normal DTRs. A bottom bunk was ordered and a referral to ADA was made. A cane was ordered but was not documented on the progress note and was difficult to find. All orders need to be evident on the progress note. There was no evidence in the record that a cane was provided though a picture on ADA rounds of 3/8/23 shows the patient with a cane. The

photo does not show evidence when the cane was provided and I suggest modifying the process to include a photo of when the cane was delivered and scan that to the medical record.

On 2/3/23 the patient placed a health request because of persistent pain from a screw in his ankle joint and complained about not getting gabapentin which had been prescribed for him from an outside physician. The request was filed in the record on 2/6/23 and a provider saw the patient on 2/9/23 at 1:27 pm. The provider noted that gabapentin was non-formulary but it was ordered but apparently not approved **(19a)**. The reason for not approving was not provided. If this medication was not approved, then DPSCS should examine the patient thoroughly or refer to someone who can address his chronic pain which is difficult but needs to be done **(18d)**.

Patient 15

This patient has two medical records **(24)**. The patient was incarcerated 11/19/21 and the IMMS documents no observable deformities but the nurse documented a prior gunshot wound to the right leg with nerve damage. But the nurse documented the patient was on no medications for this and had no medical problems. The patient was referred for urgent evaluation. The provider documented no swelling but pain in the ankle. Gait was documented as normal. The provider ordered a bottom bunk and changed the medication from oxycodone to Robaxin without documenting a rationale for the change **(17e)**.

Within about a week the patient placed a health request asking for a cane because of pain in his leg and foot. A provider evaluated the patient on 12/7/21 who said the Robaxin was not helping his pain and he asked for a cane. The provider documented his pain as 8 on a scale of 10 but documented he was able to ambulate without difficulty. There was no documented examination of the legs except the statement "extremities are normal". The provider wrote "no indication for cane at this time as patient was seen walking without difficulty".

The patient continued to complain of pain and on 12/17/21 a provider examination included the statement "tabetic; falls to R" (tabetic defined as unsteady, uncoordinated, and ataxic gait). The provider added a non-steroidal medication and baclofen. Providers were unable to address his pain but did not refer to a pain specialist or a therapist to attempt alternate treatments **(18d)**.

On 1/21/22 a physician saw patient for 10/10 right leg pain not relieved by baclofen and Robaxin. The only examination was "unsteady gait". The physician ordered a cane and a receipt for a cane was present on this date.

On 2/2/22 (scanned to 2/4/22) the patient asked for physical therapy due to leg damage. On 2/8/22 (scanned to 2/4//22) the patient placed a health request for a bottom bunk stating he had leg damage. The bottom bunk was documented as ordered on 2/8/22. A bottom bunk was ordered in late 2021 and it was unclear why the patient did not still have it **(20b, 21a)**. On 3/14/22 the patient placed a sick call slip documenting he needed a bottom bunk slip and "verification" for his cane, saying he would sue if he didn't get his bottom bunk or cane. Staff reviewed this record and noted that the patient did receive the cane but it was unclear if the patient had a bottom bunk. There is no way to verify whether the inmate was housed in a bottom bunk which makes it difficult to verify this type of complaint **(20b, 21a)**.

He was seen by a provider who said he came to clinic walking without a cane and requested a bottom bunk because he was moved and when moved was assigned to a top bunk and officers took his cane away. The provider said that the cane was seen in the officer's station and the provider wrote that the officer on the shift said he would give the cane to the patient when needed for ambulation. The cane was taken for safety reasons **(20b, 21a).** The only examination of the legs was "extremities are normal". The provider documented that the bottom bunk was re-ordered but told the patient to request the cane when needed for ambulation. This is inappropriate. The patient should have been housed on a unit where canes are permitted **(20b, 21a).**

On 4/1/22 provider note documented "he uses his cane to keep his balance. The patient asked for physical therapy but was told it was not approved. The provider advised the patient to do physical therapy by himself **(18d)**.

A receipt for a cane given on 1/21/22; a disability assessment from 1/21/22; and a housing transfer document for a low bunk from 2/7/22 were all filed in the medical record on 4/21/22 **(24)**. All these documents were misfiled without apparent reason. Patient placed multiple health requests continuously complaining of leg pain. Doctor saw him 5/16/22 documenting weakness, numbness, tingling of the R leg. The examination of foot and leg included mildly reduced range of motion of the left leg with pain with motion on right leg. Reflexes were normal but no other examination was completed. The plan of care was to continue current medication which was ineffective and a request for the patient to exercise his leg. Physical therapy for an assessment should have been ordered **(18d)**.

Bottom bunk orders were placed on 3/15/22 and again on 4/5/22. A shoe insert was ordered 10/10/22 and re-ordered 10/18/22. On 10/10/22 the patient requested a shoe to help his foot pain. A provider ordered a shoe insert but the patient didn't receive it and it was re-ordered 10/18/22. I could not find evidence that the patient received the insert. On 11/1/22 the ADA nurse documented that the patient hadn't yet received the insert. Insoles were received on 11/3/22.

The last provider note reviewed was on 3/21/23 and an addiction medicine provider saw the patient. There were two problem lists: one had chronic pain as the only problem; the second list had asthma and chronic pain as problems. The examination had an auto-filled neurologic examination documenting normal level of consciousness, orientation, memory, sensory, motor, balance and gait, coordination, and fine motor skills. This was inconsistent with prior findings of an abnormal gait. The plan of care documented "Pt advised that there is currently no space available in the suboxone initiation program, patient acknowledged. Sick call prn". While the suboxone program is not intended for chronic pain management, the patient did need management of his chronic pain **(18a, 18d)**.

Patient 16

This patient was incarcerated on 3/23/22. The nurse documented "Yes" to question 4[7] writing in the comment section "ambulates with crutches and walker". The patient was documented as being

[7] Question 4 on the IMMS says, "Does the offender have observable deformities or exhibit difficulty of movement? If yes, indicate the specific difficulties".

on no medications but was recently discharged from UMMC with diagnosis of closed fracture of right femur. The nurse took no action with respect to his disability except to state that the nurse practitioner was aware of discharge instructions **(17a)**. The IMMS was at 7:01 pm.

About five hours later on 3/24/22 at 12:04 am a provider did an assessment. The practitioner documented opioid dependence and recent discharge from UMMC for displaced comminuted fracture of his femur. He was to be scheduled for ortho-shock trauma follow up as soon as possible and the provider documented that an appointment had been made for 4/11/22. The patient was to weight bear as tolerated and to keep his dressing dry and intact until follow up but follow up wasn't scheduled for almost three weeks. CRISP was unavailable. There was no hospital report scanned to the record. Patient was noted to be ambulating with a rolling walker. The patient was admitted to MTC. But the patient didn't arrive on the infirmary for approximately 62 hours (**20b and 21a**). Patients requiring infirmary care should be promptly admitted to the infirmary.

The initial nursing note on the infirmary documented that the patient was to keep his dressing in place until follow up (with orthopedic surgery) and to keep the dressing clean, dry, and intact. The nurse wrote "During assessment no dressing was seen on the right leg but it is noticed that he has staples in four areas on the leg." Apparently, the dressing came off in the sallyport and was unrecognized. The nurse applied an ace wrap to the leg but did not document how the dressing had come off. A nursing plan of care was not specified **(18a)**. There were no sallyport progress notes except for addiction medicine so the patient was unattended in the sallyport.

The first physician note on the infirmary was 3/27/22 at 10:15 am. Pain was not addressed. The plan of care did not include when the patient was to go for surgical follow up. The provider did not address whether the dressing was still in place nor was the specialty referral addressed **(18a, 18d).** The assessments included 1) fracture of the neck of the femur and 2) open wound of the foot. The specialty appointments could not be tracked in the medical record except that the UM approval for the follow up was dated 3/28/22 **(22d, 24)**. The patient apparently had no dressing on the surgically repaired leg. There was 4 by 3 cm swelling on the lateral thigh with a diffuse hematoma. Apparently the staples were still present but their status was not documented. There was no documented assessment and plan **(18a)**.

On 3/30/22 the patient had a large hematoma to the right thigh and was sent to UMMC to rule out an infection. This was ordered at 11:47 am and the patient left the facility at 2:10 pm. In the ER, a venous Doppler was negative and a CTA of the right leg was negative for a pseudo-aneurysm. The patient was anemic (HGB 9.2) with sedimentation rate of 62 and CRP 1.6. Oxycodone was prescribed at 10 mg every 6 hours as needed with Lovenox 30 mg IM twice daily for five days.

The patient was discharged from the hospital early in the morning of 3/31/22 but the recommended medications were not ordered until 9:11 pm. DPSCS should ensure that all persons returning from the hospital or specialty care, immediately have their paperwork reviewed by a nurse to ensure that new medications are called into a provider for an order. These medication should have been promptly ordered **(17d, 19a).** Also, when patients leave to and arrive back from a hospital, there is no documentation in the medical record when the patient arrived back from the hospital. This should be done.

On 4/11/22, apparently, the patient went to his appointment to orthopedic surgery. That this appointment occurred is only found documented on a provider progress note on 4/12/22. The patient's departure or arrival back at BCBIC are not recorded in the medical record but should be **(22d)**. The 4/11/22 specialty note was scanned to the record on 3/30/22 and was very difficult to find **(24)**. The infirmary provider noted that the staples were removed at the clinic and a 2-3 month follow up was recommended but the appointment wasn't scheduled. The specialty note recommended physical therapy 3 times a week for 8 weeks for exercise, active and passive ROM, resistive exercise with strengthening, stretching, ADL retraining, functional activities, and gait training with balance. I could not find a referral to physical therapy **(21c, 22a)**. Infirmary notes were mostly cut and pasted over and over and failed to identify new recommendations **(18f)**. On 4/27/22, a provider documented a breast mass and ordered an ultrasound and TSH. A referral for follow up with orthopedic surgery was made on 6/10/22, apparently when a provider noticed it had not been made. This referral is present in the medical record but is not found in the YesCare UM Consultation Log so it was not processed.

On 4/29/22 the patient was transferred back to BCBIC from the infirmary. The transfer summary out of the infirmary included that an ultrasound was pending, but had no plan of care for the patient's femur fracture. The transfer summary did not include the prior recommendation for physical therapy, nor did it include that there should have been a pending orthopedic appointment. There was no mention of the further need for a walker or accommodation. The transfer summary is inadequate with respect to the plan of care. **(18f)**

A progress note on 5/4/22 in BCBIC listed two problems 1) displaced fracture of femur and 2) opioid dependence. There was no assessment or plan for either problem **(18e)**. The progress note failed to include pending items on the transfer summary and failed to address the disability, physical therapy or necessary accommodations **(20b, 21a)**. The patient was re-booked on 5/19/22 but questions on the IMMS were all answered "no" or were left blank **(17a)**. These re-bookings are clinically meaningless but are completed with inaccurate information. If DPSCS insists on using the IMMS for rebooking then it must be completed accurately. On 5/22/22 the patient wrote a health request complaining that he was sleeping on the booking floor since Thursday (which was the day he was re-booked) **(20b and 21a)**. He complained that his leg was hurting and that he wasn't receiving his medications **(19a)**. He complained of a lump on his chest. A provider saw the patient on 5/25/22. The physical examination for that visit did not include an examination of the chest lump nor did it include an examination of his legs or the status of his leg fracture (**18b**). Chest and right leg x-rays were ordered with an orthopedic follow up after the x-ray. There was no evident plan of care consistent with prior specialty recommendations or prior provider orders **(18d)**. Orders included extra strength Tylenol, x-ray of the right femur, an ADA evaluation, bottom bunk with a comment to refer to orthopedic surgery after the x-ray. On 5/26/22 a receipt for a walker was documented which implied that the patient had not had a continuous accommodation for his disability **(20b, 21a).** This disruption of the accommodation was unnecessary if the transfer had been transacted appropriately.

As far as I could determine the prior order for breast ultrasound never occurred **(22b)**. I could not locate the ADA evaluation **(21b)**. On 5/27/22 the patient placed another health request to see medical for his leg which was painful. On 5/30/33 a provider saw the patient and documented the orthopedic history including that the patient was to go for orthopedic follow up sometime 2-3

months from 4/11/22. The provider also documented that the patient complained of a breast lump and "possible weight loss". The patient requested physical therapy, which had been recommended by the orthopedic surgeon on 4/11/22. The doctor did not examine the breast lump nor was a functional assessment done **(18b)**. The weight was 122 pounds. A breast ultrasound initially ordered 4/27/22 but not done was again ordered on 5/30/22 **(18d)**. HIV and TSH were ordered for the weight loss. Physical therapy was ordered for gait training. There was no timely UM review of the request for ultrasound **(22a)** but the physical therapy was recommended for six session. The orthopedic specialist recommended therapy for three times a week for eight weeks or 24 sessions. Physical therapy recommended 4/11/22 didn't start until 6/21/22 **(18d and 22c)**. The patient received 23 sessions even though only six were approved but on 14 occasions the patient was not brought by custody for his appointment **(20a)** and the session was rescheduled. Staff believed that the patient had refused his appointments but therapy notes documented refusals and also documented when the patient was not brought for the appointment by custody. The breast ultrasound ordered on initially on 4/27/22 and then again on 5/25/22 was denied on 6/1/22 with a recommendation to obtain a mammogram. This was agreed to and the mammogram was apparently completed on 7/21/22 about three months after the initial order **(18d, 22a)**.

On 6/16/22 the patient again placed a sick call request asking for ensure because he was losing weight. The patient weighed 124 pounds for a BMI of 18.31. Ensure was ordered for another ten days. With the Ensure the patient began gaining weight. On 6/27/22 the patient weighed 135 pounds. On subsequent encounters the weight loss problem disappeared from documentation and was no longer followed. The patient had previously had multiple complaints about his teeth; there was no verification that he saw the dentist **(18d, 21c)**. It is questionable whether the patient was not eating due to dental problems. In any case verification and evaluation of weight loss were not done **(18a).** On 7/22/22, the assessment included only one problem; a breast lump though the patient has several problems **(18a)**. The leg fracture and weight loss were no longer followed **(18a)**. The patient was overdue for an orthopedic follow up but it appeared to have been forgotten and was no longer part of the plan of care (**18d, 21c, 22b**).

On 7/29/22, the patient asked for a refill of a prescription for Ensure. The provider noted that the patient had right hip pain as well. The orthopedic follow up was not noted as it had disappeared from the plan of care **(18f)**. The weight loss was no longer being monitored. The patient now had four problems listed: GERD, drug dependence, chronic pain, and breast mass none of which were addressed in the assessment section **(18a and 18f)**.

On 9/23/22 the patient placed a health request stating his leg was hurting and he again asked for Ensure because of a complaint of weight loss. The provider seeing the patient did not take a history of the leg pain nor was a physical examination of the leg performed **(18b)**. There were two problem lists; one consisting of femur fracture, GERD, drug dependence, chronic pain, breast mass, and weight loss. The second problem list only included gunshot injury to the right thigh and opioid dependence. The assessment was "dietary counseling". None of the problems were addressed **(18a)**. The plan was to follow up in a week in chronic clinic and have the nurse complete a weight.

On 10/5/22 a provider saw the patient and documented that the patient had undergone physical therapy with the therapist recommending follow up with orthopedic surgery. The patient was still

using a walker due to muscle weakness. The physical examination was auto-filled with "decreased mobility, limping" and negative for back pain, joint instability, joint swelling joint tenderness, muscle weakness and neck pain. Most of the document musculoskeletal examination appeared auto-filled and was irrelevant for this patient and did not address his complaint **(18b)**. The weight was 141 pounds. The assessment was femur fracture with difficulty walking and the plan was to refer back to orthopedic surgery which had originally been requested for June. The UM review of this 10/5/22 referral occurred on 10/28/22 **(22a)**.

The specialty log documents that the patient was scheduled to be seen in orthopedic clinic on 11/7/22 but there were no entries on 11/7/22 that the patient went to an appointment **(22d)**. There was no specialty consultation report that could be found in the record **(22d, 24)**. On 11/9/22, a provider documented that the patient went to orthopedic clinic on 11/8/22 but there is nothing in the medical record documenting a visit on that day; nor was a report evident in the record **(22d, 24)**. The provider documented that the patient had non-union of the fracture and needed a CT scan of the leg ASAP with return to orthopedic clinic thereafter. The patient was recommended to continue physical therapy and the provider said he ordered an urgent CT scan and physical therapy. The CT scan was approved 11/11/22. The physical therapy wasn't approved until 11/28/22 about 19 days later **(22a)**. The urgent CT scan wasn't done until 12/14/22 which is not timely as an urgent referral **(18d, 22b)** and showed non-union of the fracture. Notably, the UM log does not include an urgency notation **(22c)**, so the scheduler apparently was unaware or is not concerned with urgency.

On 12/12/22 a provider saw the patient based on a sick call request for chronic pain. The patient also complained about dental pain and the provider documented that the patient had painful dental caries in his molar teeth and had temperature sensitivity and worse pain with eating and drinking. The problem lists did not match the assessments which were chronic pain (for which there was no plan) **(18a)** and dental disorder which resulted in a referral to dental. It was not possible to determine if the dental appointment occurred and based on the repeated dental requests for this patient it appeared that this appointment did not occur **(18d, 21c)**.

On 12/14/22, the patient apparently had an urgent CT scan which was ordered 11/9/22 and completed over a month later. The CT scan showed non-union of the fracture. On 12/19/22, the CT scan result was noted by a provider who referred the patient for orthopedic follow up. The patient was referred back to orthopedic surgery. This referral was approved on 12/20/22. This referral was not found on the specialty schedule log **(22c)**. On 1/16/23 a provider saw the patient who was requesting Ensure supplement. The provider documented that the he was unable to assess the weight because there was no scale in the clinic. The provider wrote, "Unable to assess patient's weight at this time due to no scale present on the tier. His current weight is 140 pounds with a height of 5 feet 9 inches giving a BMI of 20.7. Patient was informed that per his BMI, there is no indication for continuous ensure". This was incomprehensible. If the patient couldn't be weighed how was a weight obtained? The patient failed to return to see the orthopedic surgeon **(18d, 21c)** and on 2/1/23, about six weeks after the CT scan, a provider referred the patient back to the orthopedic surgeon; this received UM approval the same day.

On 2/16/23 an ADA nurse evaluated the patient and wrote, "Detainee has an H/O femoral fracture s/p ORIF [open reduction internal fixation]. He uses a walker to aid ambulation. The detainee is

assigned a bottom bunk bed and has no medical concerns at this time". This note failed to acknowledge the actual status of the patient who has been in constant pain, had a non-union of his fracture, had missed appointments, was late for an orthopedic appointment, and had considerable dental issues which did not appear to be addressed **(21c)**. Communication about the patient needs could be more effective.

On 2/22/23 a provider wrote a note that the patient was seen by the orthopedic surgeon on 2/20/23. There was no consultation report in the record, nor was there documentation the day of the consult that the consult occurred **(22d, 24)**. This appointment was in follow up of a request for an urgent follow up from 11/8/22, three months earlier **(18d, 21c)**. There was no evidence in the medical record of an offsite visit on that date and there was no report of the specialty visit in the medical record **(18f, 22d, 24)**. The provider wrote, "Patient is currently on lock up and thus was unable per his report to bring his walker down. He is noted to be limping in the dispensary by this provider". This would be inappropriate and cruel if accurate as the patient did not have a necessary accommodation. The provider ordered the surgery. As of 3/23/23, there was no new information in the medical record.

Patient 17

Another patient was 31 years old and on 9/14/22 at 7:40 pm a nurse performed an IMMS and answered "no" to whether the patient had a deformity or exhibited difficulty of movement **(17a)**, which was clearly inaccurate because the patient had just been discharged from a hospital and was documented as having a lower extremity fracture needing follow up. The nurse answered "no" to questions about whether the patient used medications or had medical problems but the patient had asthma and used inhalers **(17a)**. Yet in a comment section, the nurse documented that the patient had asthma, and used heroin. Remarkably the patient was just discharged from the hospital. The hospital after-visit summary stated that the patient had a "mechanical complication of an internal fixation device" and recommended to "schedule an appointment with Johns Hopkins orthopedics as soon as possible for a visit in 2 weeks (around 9/28/2022)". Yet this was unrecognized by the nurse who made no comment about the hospital recommendation (**17a)**.

On 9/15/22 at 1:33 am a provider saw the patient and documented that the patient previously had surgery done for a gunshot wound to the leg. There were two problem lists which were different **(18a)**. When incarcerated he was rejected and sent to a hospital emergency room. The doctor reviewed CRISP and documented that the patient had a history of a high impact fracture with prior surgery in May of 2022. The provider wrote a summary of the CRISP note from the emergency room but it was an incomplete summary. The CRISP note was not place in the medical record. The after-visit summary from the hospital recommended a follow up orthopedic appointment as soon as possible (in two weeks) with a recommendation for a 9/28/22 follow up. The CRISP note recommended regular follow up for pain management follow up and follow up with orthopedics in 1-2 months for fusion surgery. The actual CRISP summary recommended no durable medical equipment and a 1-2 month follow up for fusion surgery. The CRISP summary should be copied and scanned to the medical record because it is a report of the ER visit. Because the CRISP note was not in the medical record, my initial reading of the record was uninformed by the ER visit and my interpretation of care was different. The provider ordered a referral to addiction medicine but did not refer the patient for an orthopedic appointment **(18d)**. The right ankle was described as

swollen with a healing surgical site. The plan of care included ordering laboratory tests, medication for his asthma, opioid withdrawal, sedative withdrawal, and alcohol withdrawal. The only plan for his pain was to order ibuprofen for pain. The provider ordered a referral to addiction medicine but did not refer the patient for an orthopedic appointment **(18d)**. A bottom bunk was ordered only for ten days.

It wasn't clear if an appropriate housing accommodation was made because the housing location was not in the record, but on 9/20/22 the patient placed a health request saying he was having a hard time walking on his ankle because of the pain. He said he wasn't receiving ordered pain medication. On 9/22/22 a provider saw the patient and added Robaxin for pain but no other accommodation was made. There was no evidence that the patient had a cane, crutches or a walker since being incarcerated. On 9/23/22, a provider documented that at the hospital it was recommended to follow up in 1-2 months for an ankle fusion**.** The doctor documented that the hospital recommended "to continue WBAT [weight bearing as tolerated] with no DME [durable medical equipment]". The actual CRISP note stated, "We will allow him to continue WBAT with no DME". Given the pain the patient was having when walking, using a walker or crutch would have been appropriate especially since fusion surgery was planned. As well, additional pain medicine was indicated as the patient was on a moderate dose of ibuprofen. Instead of referring the patient to the orthopedic consultant, a referral to an onsite podiatrist was made**.** I was told that for foot and ankle issues, the program uses the onsite consultant podiatrist as a substitute for evaluations. However, this appeared to merely delay care.

On 10/6/22 a provider documented that the podiatrist was to see the patient "today" but this consultation had not occurred on 10/6/22. The same day, on 10/6/22, a provider ordered crutches (verified on a disability assessment form) and a transfer of housing assignment documented transfer from the sallyport to "ADA housing". The document stated that the patient used a walker. There was no evidence of the patient having a walker though he may have had one. Since incarceration, it appeared based on documentation in the record that the patient was housed in the sallyport and was without accommodation to assist in walking **(20b and 21a)**. It would be helpful if each note documented the current housing location of the patient to verify whether they are still in the sallyport **(24)**.

On 10/12/22 another IMMS was completed due to "rebooking". All questions on the IMMS were entered "no" which was inaccurate. This inaccurate IMMS is unnecessary and DPSCS must ensure that rebooking does not result in a second intake screening particularly since the IMMS that is entered for rebooking is inaccurate **(17a, 24).** Why is an IMMS necessary for rebooking? The patient is an active patient who already had an IMMS.

The podiatry consultant note actually occurred on 10/12/22 but I could not initially locate this note. A staff member found it for me. It was documented as a med_chm_provider_visit note, on 10/12/22 which is a routine provider note. One would not know it was a consultant note and in order to find it, one has to open every note in the possible time-span when it is presumed the patient may have been seen and examine the names of the author of the note **(18f, 22d, 24)**. This makes the placement of a consultant's note obscure and extremely difficult to find. This provider provides wound care and podiatry consultations to BCBIC. It makes sense that his notes be labeled on the "patient history" section as "wound consultation" or "podiatry consultation" as appropriate. (**24**).

The podiatrist evaluated the patient and agreed that he needed fusion surgery and referred the patient to an orthopedic surgeon.

On 10/19/22, a week after the podiatry consultation, a provider documented that "per the patient, podiatrist also ordered boot for the patient". However, the podiatrist note did not include a recommendation for a boot and there was no order for a boot **(20b, 21a).** Notably, in ADA rounds report, there is a picture of this patient with a walking boot on but I could not find an order for a boot. This is a delayed and inaccurate review of the podiatry consultation contributed to by defective medical record consultation documentation **(22d)**. The provider documented referring the patient for surgery and documented on the referral form (med_chm_consultation) that fusion was recommended by an orthopedic surgeon and the in-house podiatrist. The referral to orthopedic surgery dated 10/19/22 was not approved until 10/31/22 which is not timely **(22b).** I could not locate an order for a cast boot, but on the ADA rounds report, there is a picture of the patient with a cast boot. I could not find in the medical record and order for the cast boot nor who ordered it (**20b, 21a**).

Providers documented that an orthopedic surgeon wanted an x-ray done prior to evaluation for surgery. An appointment with the orthopedic surgeon was scheduled for 11/11/22. The x-ray was completed on 11/2/22 and the report was available on 11/7/22. A report by the orthopedic surgeon dated 11/11/22 documented that the patient was not physically examined and that the x-rays requested to be sent were not sent. The surgeon requested that the x-rays be sent, stating he would review the films when they arrived and call about follow up. The orthopedic doctor wrote that the patient should continue crutches and walking boot. Crutches were ordered 10/27/22 but an order for the walking boot was not found **(18f)**. There was no evidence or scheduling of orthopedic surgery follow up.

At least two orthopedic surgeons and apparently the podiatrist all agreed that the patient needed fusion of the joint but the process of getting this done was disjointed, ineffective, and delayed. On 11/14/22 a provider wrote that the orthopedic surgeon wanted a repeat x-ray and documented ordering the x-ray. However, the orthopedic surgeon said "I asked for x-rays to be sent soon". This implied to me that he didn't ask for repeat x-rays. However, I was unable to find an order for an x-ray for this date. But a staff member did find for me an order on 11/15/22 for an x-ray that was cancelled. An 11/25/22 note documented that the patient was using a CAM boot (there was no order for this I could find), was not using crutches (for which there was a receipt and disability assessment) and was awaiting a follow up x-ray which was documented as ordered on 11/14/22 but cancelled on date uncertain. The lack of clarity in finding orders, consultations, and cancellation of orders is a problem **(24)**. The plan of care documented in the assessment and plan did not clearly define what was to occur and when it was to occur **(18d, 22d, 24)**.

On 12/1/22, a provider documented receiving a call from the orthopedic surgeon who recommended revision of the failed prior open reduction of the fracture and the provider emailed the scheduler to schedule the surgery. The offsite log documents that the surgery was scheduled for 12/14/22. On 12/12/22 a pre-operative evaluation was completed. On 12/14/22 the patient refused surgery.

Follow up on 3/8/22 documented that the patient said he was to be released 4/3/22 and wanted to have the surgery where it was initially performed (at Johns Hopkins Hospital) and elected to wait for discharge to return there for the surgery. The ADA log had a picture of the inmate's leg with a cast boot on and crutches beside the inmate.

Patient 18

Another patient was incarcerated on 2/9/23. The IMMS at 12:36 pm documented a "no" answer to question 4, whether the patient had physical deformity or exhibited difficulty in movement. Yet, in the comment section, the nurse documented that the patient used a wheelchair due to multiple gunshot wounds. Further details were not provided. These are contradictory statements. The nurse documented "yes" to the question whether the patient was in pain and was prescribed medications but documented "no" to the question whether the patient had any medical problems. In the comment section, the nurse documented that the patient hadn't received any pain medication this morning, but there was no documentation that the nurse ensured that the patient received recommended medication or accommodation **(17a)**.

About 9 hours later at 9:15 pm a physician assistant documented an intake assessment. The provider documented that the patient was just discharged from the trauma unit after a nine day hospitalization. Details of the hospitalization were not in the medical record **(22d)** and follow up recommendations were not documented. The problem list included chronic pain, esophageal reflux, and COVID, but there was no evidence for a COVID infection and the gunshot wound was not documented as a problem and the patient obviously had a mobility disorder **(18a)**. The provider wrote that the patient was released.

At 1:21 am on 3/6/23 the same patient was re-incarcerated. The IMMS was completed at 1:21 am. In this IMMS the nurse answered "no" to all medically related question including that the patient had no observable deformity or difficulty with movement or that the patient had any medical problems. The nurse did answer "yes" to the question about taking medications and in the comment section referred to the hospital discharge summary from 2/9/23 which was appended to this note. The nurse failed to document that the patient was hospitalized for a gunshot wound and previously had been in a wheelchair. The medications were not listed and the nurse did not ensure that the patient had received medication **(17a)**.

At 2:01 am on 3/6/23, a provider saw the patient for an assessment and documented that the patient was in a wheelchair from a gunshot injury. The gunshot was documented as occurring to the spine, right hip and right ankle. The patient had no open wounds but had a cast on the right ankle. The patient reported a follow up orthopedic appointment on 3/24/23 but there was no hospital record and the appointment was not in the after-visit summary. The patient was prescribed oxycodone, gabapentin, Flexeril, and lovenox upon discharge. On examination, the patient had moderately reduced range of motion, a cast on the right leg, unsteady gait, and normal reflexes. Strength was not assessed. Nor was it clear whether the patient had any paralysis due to the gunshot wound. Though the patient described 10/10 pain aggravated by movement, no further pain history was taken. The plan of care was to reduce pain medications from 10 mg oxycodone to tramadol 50 mg. Lovenox was continued. A tapering dose of gabapentin was ordered to discontinue in a week. Flexeril was discontinued. Methocarbamol was started. There may have been good reason for the

change in medications, but there was no explanation for any of these medication changes **(17e)**. The patient was referred for orthopedic follow up at the hospital where the patient was cared for. This appointment was approved on 3/8/23. A wheelchair and a low bunk were ordered. I couldn't find an ADA referral though staff tell me that there is an ADA notification email distribution that is sent out anytime a new ADA patient comes in. However, the medical record contains no documentation of this. Why isn't ADA status documented in the medical record **(21a, 20b)**?

Despite no documentation of a referral, on 3/8/23 an ADA nurse saw the patient. It was not clear that the patient was appropriately housed as the housing location is not present on the record (except to state BCBIC). The nurse did document that the patient was not receiving pain medication and told the patient to place a health request for this purpose. This did not address the concern of the patient **(21b)**.

On 3/12/23 the patient wrote a health request that he wasn't receiving his medication. That day a provider wrote that ordered labs were not yet in the electronic record[8] **(19f)** and the patient did not get his ordered pain medication (tramadol or gabapentin). I could not verify this in the medication administration record because these records are not in the electronic record **(19a).**

On 3/24/23 a provider documented that the patient was seen in follow up by orthopedic surgery but there was no consultation report in the record (**18f, 22d, 24**).

Patient 19

This patient had the wrong SID number on his ADA rounds report. The number on the report yields no medical record. I asked for his correct number. That number yielded two medical records; both have information in them. I reviewed the medical record with the IMMS **(24)**. The patient is also documented as deceased on the banner bar which is inaccurate **(24)**.

The IMMS was performed at 10:30 pm on 2/21/23. The blood pressure was elevated at 150/81. The nurse documented that he used a cane and was observed to have adhesive bandages on two of his fingers. The nurse did not remove the bandages or ask why he had bandages on **(17a)**[9]. The nurse documented that the patient was just discharged from the hospital diagnosed with hypertension and opioid overdose. The patient said he used heroin; the COWS was documented as 0. The nurse documented that the patient was on no medication but did not review the hospital patient discharge instructions **(17a)**.

About five and a half hours later, at 4:07 am on 2/22/23 a provider performed an intake assessment. There was no discharge summary only patient after-visit instructions. The patient medications were listed as amlodipine 10 mg, aspirin, atorvastatin 40, doxycycline, gabapentin, Lisinopril 40, losartan 50, nifedipine 90 ER, and topical sulfadiazine. CRISP was unavailable and the provider

[8] The result tab shows labs completed 3/8/23 but these were the date of order. The date the lab result is inserted into the record is not recorded. This misinforms with respect to 19f because the date the lab is completed is not clear.
[9] I was told by a staff member that the current procedure is for nurses to perform screening but not assessments such as wound checks and that the nurse intake area is not set up with supplies necessary to perform wound care.

depended on the patient for a history.[10] The patient reported stroke in 2016 and a head injury at an unspecified time for which he underwent cranial surgery. He reported a leg injury two weeks ago and used a cane for support. The provider also documented hypertension and frostbite injury to fingers of his right hand at a time unknown. There were sutures in place with granulation tissue and no sign of infection. Blood pressure was 153/100. A cognitive assessment was not performed on physical examination. The only neurologic examination was auto-filled and documented normal memory, normal cranial nerves and normal "sensory". I talked to this patient on tour and he had obvious cognitive issues and was unable to remember important details of his medical history yet was documented as having "normal" memory. The auto-fill function should not be used or should not be used in this manner **(17b)**. The provider assessed three problems: 1) hypertension, 2) opioid dependency, and 3) "encounter for other specified surgical aftercare" which apparently was intended for his frostbite injury which was a temporary condition. The history of stroke, cranial injury, high blood lipids, and apparent cognitive injury were not addressed **(17b, 18a)**[11]. The plan of care was to start Lisinopril and medication for withdrawal but the provider did not address the other medications listed on the after-visit summary nor did the provider state why he did not continue those medications **(17e)**. The patient's stroke and cranial injury histories were not addressed in the examination nor in the plan which at a minimum should have included obtaining old records **(17b)**. CRISP should be reinstituted as it is a critical source of information for providers. Appropriate labs were ordered except lipid studies; the patient was on a statin based on hospital records and his status should have been verified **(18a)**. The provider documented that the patient already had a cane and ordered a bottom bunk and submitted "ADA". The provider documented "transfer of housing form completed" but this patient needed protected housing due to apparent cognitive issues. Where the patient was being housed should have been stated and DPSCS should consider admission protocols and procedures for specialized medical housing (e.g. infirmary, specialized ADA units, detoxification units, diabetic units, etc.) **(20b and 21a).** Wound care and referral to chronic clinic and addiction medicine were ordered. COWs monitoring was ordered but the precise order including number of days and times per day was not documented in the plan **(17b, 18c)**. The order for COWS monitoring on the MED CHM Home Page was "withdrawal monitoring- alcohol and drug". This order is imprecise and unclear (18f, 24). The assessment and plan section of the health assessment on 2/22/23 had the statement "COWS monitoring and 1st dose of medication given. The record does not appear to have a standardized order format for COWS and CIWA **(24)**

On 2/22/23 at 10:53 am, addiction medicine saw the patient. The blood pressure was 178/110. There had been no documentation of receipt of medication since arrival though the medication administration record was not present in the medical record. The patient's blood pressure was

[10] This patient was interviewed on tour. He appeared to have cognitive issues and indeed reported prior stroke and brain injury resulting in surgery. He did not appear cognitively intact.

[11] Staff commented to me about this criticism stating that stroke was identified and it was identified that the patient had prior cranial surgery. The staff stated that further neurologic examination might be appropriate in a chronic care clinic but "not at a sally port initial assessment designed to identify medical issues". My point here is twofold 1) the neurologic examination was inaccurate and auto-filled 2) the purpose of the intake assessment is to identify all problems, determine the needs of the patient and ensure that ongoing care is ordered and takes place. In this case, the patient has some cognitive dysfunction probably due to his brain injury. A cognitive assessment should have been performed to assess whether protective housing was needed. A neurologic examination was needed to determine whether the patient had a functional disability for which he needed protection. This should be done in intake and not later in a chronic care clinic. If the patient had high blood lipids his medications should have been ordered.

rising since arrival. The addiction medicine provider documented in the plan to perform COWS/CIWA three times a day for five days. I could not find this order in the orders in the MD Med Chm Home Page and could otherwise not find the order.

The Patient Demographic tab → MED CHM Detox tab shows that COWs testing was performed three times on 2/22/22 but all three tests were completed at 11:45 am, 12:21 pm and 12:25 pm; once on 2/23/22; twice on 2/24/22 and once on 2/25/22. There were multiple missed tests if testing was to occur three times a day for five days **(19c)**. On 2/23/22, nurses attempted to perform COWS three times but could not locate the patient **(20c)**. Initially, at 5:43 am the nurse was told that the patient was moved to the 4N unit. Twice later in the day at 10:39 am and 5:35 pm, nurses went to the unit but nurses were told that the inmate was not on the unit. It appeared to take over 12 hours for the inmate to be moved and his location was not known. A second problem with the CIWA and COWS is that there are multiple options to enter results of the COWS and CIWAs. The method of entering data, including what data is to be entered should be standardized for these procedures and the same methodology should be used in the medical record **(19c).** Last, the chm_detox_monitor note from 2/24/22 at 3:12 pm has a table providing a summary of recent COWS. The times the COWS were performed on this table do not coincide with the times provided in progress notes in the patient history timeline. There appears to be a date/time stamp issue with this medical record such that times of notes in the patient history timeline do not consistently correspond to the actual time the note was written. This must be corrected **(24)**.

On 2/27/23 at 3:35 pm a provider evaluated the patient in a chronic clinic for "cardiovascular, neurology, and pain management". This note was competed at 10:51 pm (approximately 7 hours later) and it was unclear when the patient was actually seen. Procedures for when a note is to be date/time stamped should be determined in policy **(24).** The problem list included 1) hypertension 2) opioid dependence 3) traumatic brain injury 4) amputation of fingers 5) CVA [stroke] 6) dyslipidemia and 7) left sided weakness. In a history section titled "Hx of HTN/Dyslipidemia/CVA" the provider wrote that the patient hadn't received blood pressure medication in two days **(17d)**. The provider also wrote what appeared to be an auto-filled statement, "He denies hx of CAD/MI, CHF, arrhythmia, PVD, CVA/TIA". This appeared to contradict the history that the patient had a stroke. This was very confusing and appeared to be an issue more with use of auto-fill **(18a, 18f)**. The patient was 48 years old and was identified as having anemia of chronic illness. The patient wanted additional narcotic medication related to his withdrawal and terminated the evaluation before it could be completed. The assessments did not match the problems in the problem list but this was likely related to the truncated evaluation. Multiple laboratory tests were ordered for this patient which as of 3/27/23 had not been done **(19e)**. The order for wound care was nonspecific in the assessment and plan ("wound care until healed") but there was an order in the MD Med Chm Home Page screen that specified "wound care daily. Cleanse wound daily with normal saline; paint with betadine; apply xerofoam and wrap with Coban/kerlex". If these are the doctor's orders, why can't these orders be placed in the assessment and plan section of the progress note.

The patient missed some wound care. He refused care on 21/28/22 and 3/2/22 but was not seen on 3/4/22 and 3/5/22. On 3/8/22 the patient was in medical and did not receive care. On 3/10/22 a nurse gave the patient a wound kit to clean his own wound. This would have been appropriate if the patient was cognitively capable of dressing his own wound.

On 3/8/22 a provider saw the patient for addiction medicine follow up. The blood pressure was 174/114. The COWS was 11 and the practitioner documented, "He reports he was started on methadone few days ago but he has not received the methadone x 7 days". Methadone was restarted. 40 mg of methadone had been started on 2/25/23 and was restarted at 30 mg. The blood pressure elevation was not addressed; nor was it clear if the patient was receiving medication for hypertension **(18b, 19a-b).** COWS monitoring was ordered TID for five days but there was no evidence that the COWS tests were done **(18b, 19c)**. The examination of this patient included "normal" auto-filled examinations that included the musculoskeletal and neurologic examinations that included "normal gait" despite needing a cane for an unsteady gait; "normal inspection and range of motion" of the hands despite having amputations from frostbite with ongoing wounds to the fingers; and normal range of motion of the lower extremities despite a disability from a stroke resulting in difficulty walking. The neurologic examination included auto-filled entries documenting normal memory, normal motor, normal balance and gait and normal coordination despite obvious gait and cognitive defects due to a prior stroke and traumatic brain injury. These auto-fill examinations should be discontinued or used properly **(18b)**.

The patient was evaluated again on 3/16/23 in follow up chronic clinic for "internal medicine" but it was unclear what the patient was being seen for. The doctor documented that the patient had fallen but didn't know where he had fallen. The provider noted that the patient did not support himself with the cane when he walked. He could walk without the cane but had "lateralizing signs" with left body weakness. He was described as speaking slowly and was sometimes forgetful. He was referred for skilled nursing housing. The blood pressure was 150/90. There was no mini-cognitive assessment **(18b)**. The problem list contained seven problems: 1) hypertension 2) opioid dependence 3) traumatic brain injury 4) history of amputation 5) stroke 6) dyslipidemia 7) left sided weakness. But the assessment included only five problems 1) stroke 2) hypertension 3) frostbite with tissue necrosis 4) traumatic brain injury and 5) hyperlipidemia. The opioid dependence and status of treatment for opioid dependence was not mentioned. The hypertension was documented as controlled but was not . The provider should have considered increased antihypertensive medication. The traumatic brain injury was yet undefined. The patient was placed on a skilled nursing unit but there was no cognitive assessment nor was a thorough neurologic examination done **(18b)**. The patient appeared to have been released from the jail as the patient was not admitted to the skilled unit and there were no further notes.

Patient 20

This 26 year old woman was incarcerated 6/19/22. Her IMMS documented "no" to the questions whether she had a medical problem or was on medication. Yet, she had been following with a rheumatologist for a severe collagen vascular disease and was on prednisone and hydroxychloroquine **(17a)**. The comment section documented that she had Sjogren's syndrome and asthma. She was referred urgently to a provider. It is unacceptable for nurses to fill in the comment box but answer all other questions "no".

The provider seeing the patient documented her conditions but failed to identify her medications. Though Sjogren's syndrome was identified, it was not listed as a problem and there was no assessment or plan for the condition. An appropriate plan would have been an urgent referral to

her rheumatologist **(18a).** As a result of not identifying her medications, the patient failed to continue medication that she was on in the community which was critical for her treatment **(17d).**

About three weeks later on 7/12/22 the patient placed a health request stating she needs her medical records ASAP because she was having a lupus flare up. A provider saw her and documented looking in CRISP and identified that she had Sjogren's syndrome and was followed at a local rheumatology clinic and had been prescribed hydroxychloroquine and prednisone. The doctor confirmed with the pharmacy that this was accurate. The doctor documented she would order a "short course" of prednisone and consider rheumatology referral. The patient should have been referred to the rheumatologist as it is unlikely anyone at BCBIC was familiar with treating Sjogren's **(18d)**. A nurse practitioner saw the patient in follow up and did not refer the patient to a rheumatologist but continued the prednisone. The hydroxychloroquine was not started because the patient was pregnant. Though hydroxychloroquine is used in pregnancy, the decision whether to restart the medication was probably best made in consultation with the rheumatologist. So the physician's decision was appropriate, but the patient should have been referred promptly back to her rheumatologist.

The patient was referred to a rheumatologist on 8/5/22. The patient was referred urgently and the utilization review was done 8/8/22 which is not timely for an urgent referral **(22b)**. Moreover, the urgent referral wasn't completed until 12/27/22, 144 days later (approximately 5 months later) **(22b).**

The patient's prednisone expired 8/12/22 without anyone noticing until the patient placed a health request on 8/12/22 stating she hadn't been receiving her medication **(19a)**. The prescription was renewed on 8/16/22. Beginning in August and continuing through September, October and November, the MARs show a prescription for hydroxychloroquine that was one of her recommended medications. However, there was no order for this medication in the medical record. Apparently, a provider had initially ordered the medication but canceled the order because of the patient's pregnancy. The canceled order was not transmitted to the pharmacy and the pharmacy continued to produce medication administration records even though the patient was not prescribed the medication. Because the pharmacy continued to send MARs, a continual risk was present of medication error. Nurses, in their daily reconciliation continued to write "D/Cd" on the MAR and the patient didn't receive the medication. However, this error suggests that the interface between the pharmacy and the electronic record is defective **(24)** and places inmates at risk of harm via medication error.

On 9/20/22 the patient placed another health request stating "I need my prednisone". Her prescription had expired on 9/16/22 without anyone recognizing it **(19a)**. The medication was renewed, but I could not find a progress note in the medical record documenting the renewal. The patient started receiving the medication again on 9/21/22.

On 10/5/22 a provider wrote that the patient had a pending rheumatology consultation. An urgent referral was made on 8/5/22. A December appointment was confirmed on a 10/10/22 chronic care visit but the referral was not found on the offsite specialty log provided to me and the appointment was not timely **(22b, 22c)**.

Patient 23

This patient had prior incarcerations. On 2/16/21 he was re-incarcerated. He was identified with bilateral leg amputations and was sent to a hospital for burn wounds on his hands and "altered mental status". At the hospital a CT scan of his brain showed possible age indeterminate white matter infarction (stroke), and area of encephalomalacia, and extensive white matter disease consistent with chronic ischemic changes. Clinical correlation was advised. A discharge summary was not available, only an after-visit summary with the CT scan result. The intake health assessment was performed after the hospitalization but no neurocognitive testing or neurologic examination was done to determine if the patient had a cognitive disorder and there was no follow up of the abnormal CT scan. This was not documented as a problem **(17b, 18a).** The patient had bilateral leg prostheses but these were not evaluated. The patient had known mental health disorder and was following with the mental health program.

On 2/21/21 at 2:42 pm the patient was seen based on a sick call request and asked for parts to repair or replace his prosthesis. The patient was referred to podiatry but a utilization approval could not be located. And the podiatry note was not labeled so I did not open every note in an attempt to find the consultation.

On 2/23/21 a provider saw patient and documented that getting a "history is challenging as patient is a poor historian and uncooperative". No cognitive evaluation occurred **(18b)**. The neurologic examination documented "grossly normal intellect" with "intact" memory. The mental status note was appended to state that the patient was "somnolent". Clearly, this is an auto-filled note. On 2/23/21 referred to Dr. Berger for burn wounds to his hands. Notably the wound provider is the podiatrist so two consults were pending for this in-house consultation. The podiatrist notes are documented as provider notes in the EPHR and are not possible to distinguish from ordinary notes so every note has to be opened to determine if the patient was seen.

On 5/1/22, the patient placed a health request that was unclear. It stated "procstecctic I need help". I presumed this was related to his prostheses. On 5/2/22, the patient placed another request asking "I need to see someone about my prosteric". On 5/3/22 there was documentation that the patient refused sick call.

On 5/5/22, an ADA nurse saw the patient and documented "Detainee has h/o chronic pain to right lower leg S/P ORIF [open reduction internal fixation] and ambulates with a cane. Assigned and seen on bottom bunk is able to independently perform ADLS. Denies any medical concerns at this time". This patient had amputations with two prosthetic legs and did not have ORIF. This person had just placed a health request. No one had addressed his health complaints. The ADA nurse had ineffective communication with the inmate who wanted his prosthesis fixed but it wasn't recognized **(21b)**. The patient had severe mental health disorder and probably old stroke or possibly early dementia which had not yet been evaluated.

On 5/12/22, a provider saw the patient for sick call, presumably related to the 5/2/22 request. The nurse practitioner documented that the patient had bilateral amputations and was "requesting to know the status of his prosthetic. He reports he has a pair here but can no longer fit". The provider plan was "patient reassured". The only examination was of the extremities was "BK [below knee]

amputation". This was an inappropriate evaluation as it did not address the concerns of the patient **(18c).**

On 6/24/22, an ADA nurse documented "Detainee has bilateral BKA and uses a wheelchair to assist with mobility. He is assigned and seen on bottom bunk bed and is able to perform ADLS without assistance. He denied having any concern during this visit". Though the patient was using a wheelchair, there was no apparent order for this equipment **(20b, 21a)**. The following day a receipt for accountable items documented a wheelchair was provided to the patient. His prostheses were not addressed **(20b, 21a)**.

On 8/23/22, the patient placed a health request stating "I would like to be seen at chronic care. I want to be seen about my prostec leggs". A provider saw the patient the same day. The provider documented that the patient was referred by the warden because of his prosthesis. The patient had bilateral below knee amputations (BKA) likely due to complications from diabetes. The provider referred the patient to an orthotist for refitting of his prosthesis. An initial utilization decision was on 9/6/22, 13 days later, and was a denial stating "as IM states the prosthetic does not fit due to weight gain, the next step would be to verify such by conducting an objective examination with the prosthetic on". The utilization decision was not timely **(22b)**. On 9/6/22, at 12:43 a doctor wrote an administrative note documented that the patient was evaluated on the housing unit and the prosthesis did not fit due to weight gain. Ten days later, on 9/16/22, the patient was approved for a prosthetic fitting. The utilization decision ws not timely **(22b)**.

On 10/10/22, the patient told a provider that he was waiting for an orthopedic assessment to assess his prosthesis. The provider wrote that the orthotist appointment is “not coming soon”. This sequence is a delay in getting a proper evaluation of the patient **(22b)**. The provider referred the patient to an orthopedic surgeon but the utilization review was on 10/17/22 and denied the referral saying there was no medical necessity. The utilization review was not timely **(22b**) and gave providers no option to evaluate the prosthetic device **(20b, 21a, 22b)**.

The offsite specialty log documented that on 10/11/22 the patient went for a consultation with the orthotist. However, there was no evidence in the record that the patient went for a visit on that date. Nor was a consultation report present so there was no evidence of the consultation **(22d)**.

On 10/12/22 the patient saw an ophthalmologist who documented that the patient did not have diabetic retinopathy, but did have a macular hole. This can cause visual disturbance and vision loss. The ophthalmologist recommended referral to UMMS retinal clinic for treatment. This recommendation went unrecognized until 2/10/23 (four months later) when a provider referred the patient to UMMS retinal clinic. As of 4/3/22, the patient has not gone for this appointment **(22a, 22b, 18d)**.

The patient had previously had anemia and again had anemia (hemoglobin 10.8) on 8/25/22. The hemoglobin reverted to normal (12.9) on 10/5/22. The patient was 51 years old. The blood count was not repeated but given his age a colonoscopy was indicated. A provider noticed the anemia almost three months later on 11/18/22 and documented that he would refer the patient for colonoscopy. However, the referral form did not include colonoscopy on it. The referral form included four referrals none of which had a date appended to it so it was not clear what the referral

form was for. The patient was not referred for colonoscopy, though intended by the physician, and never went for his colonoscopy. This may be a problem with the referral process, the referral form, the medical record, or lack of training of staff on how to use the medical record (**22a, 24)**.

On 11/23/22 the patient was admitted to the infirmary for being non-communicative and refusing insulin. The infirmary physician referred the patient to an orthotist for a new prosthesis because the old one did not fit. This referral was not found on the specialty care log **(22c)** nor was a utilization decision completed **(22b)**. The patient's accommodation was not addressed **(18d, 20b, 21a)**.

Though there was no utilization decision documented in the record, on 11/30/22 at 9:06 am, a provider documented discussion a utilization denial with the patient. Though the alternate treatment plan (ATP) is not in the record, the physician documented that the ATP recommended weight loss and the doctor's plan was to attempt weight loss for two months and re-evaluate. The weight loss plan in this patient with mental illness and possible cognitive disorder was unclear. This was not an appropriate plan of care **(18d)**, in my opinion. The patient should have had an orthotist evaluate the prosthetic, determine if was useable, and then make a determination on a course of action. Also, this patient needed a cognitive evaluation given his history of possible stroke and evidence of brain changes consistent with senility.

The patient was discharged from the infirmary on 12/13/22 and remained in the sally port for a few days. On 1/17/23 a provider in the new housing location documented that he needed the report of the orthotist which apparently occurred on 10/11/22 about three months ago (**22d)**. The doctor wrote, "when is the follow up? What is plan for fitting? Schedulers have been emailed". I completely agree with this provider. The medical record is uninformed regarding his plan of care **(22d, 24)**. On 1/25/23, the patient asked about his prosthesis. The provider documented he was waiting on a report from the orthotist.

As of 4/3/23, there is no evidence of a utilization review for the orthotist appointment. Nor does the medical record have an adequate plan of care for his prostheses. It is possible that the vendor is delaying treatment but the plan of care in the record is uninformed and uncertain **(18a, 18d)**.

Record Review Deficiencies 20 Records	
17a	32
17b	35
17d	7
17e	4
18a	61
18b	24
18c	5
18d	34
18e	4
18f	13
19a	10
19b	2
19c	6
19d	0
19e	11
19f	3
19g	0
20a	1
20b	32
20c	2
20d	0
21a	34
21b	4
21c	7
21d	0
22a	11
22b	24
22c	8
22d	30
24	48
Total	**452**

This table should be taken in the perspective that the chart selection was geared toward those with disabilities. Also, administration of medication was only documented when a provider or staff member documented that the patient hadn't received medication. So, the table grossly underrepresents medication failures as no MARs were evaluated. Similarly, not all orders were evaluated so order failure is likely underrepresented.

The plan of care (18) was affected by the defective problem list and the failure of the problem list to populate the assessment and plan. This is a medical record issue as the set up and configuration of the record was not done in conjunction with providers or with respect to the requirements of the Settlement Agreement. Identification of disabilities and need for accommodation must begin in intake but this does not occur, especially for nurses. The IMMS does not appropriately identify disabilities nor ensure that accommodations are timely made. Specialty care documentation is very poor. Few discharge summaries are present in the records; instead, only after-visit summaries are made available, but these do not typically have clinical information. Specialty care scheduling, approval, and documentation is opaque difficult to find. The mechanism to order specialty care in the electronic record is so confusing and unintelligible that it is hard to determine what is being referred and when the referral was made. This is a medical record issue that is a major bug. The 17a errors are almost all quality issues; a few were for not completing the IMMS.