MEDICAL QUALITY ASSURANCE MONTHLY RESULTS REPORT

PROJECT DETAILS

Name	Alameda County Sheriff Office – Medical Operations Consulting: Medical Quality Assurance Review		
Sponsor	Lieutenant Joseph Atienza, Contracts Lieutenant	**Project Manager**	Tami Bond
Project Summary	To provide Medical Quality Assurance (QA) services for the Alameda County Sheriff Office (ACSO) through the performance of Medical QA reviews to evaluate timeliness of care, appropriateness of assessment, treatment, type of Provider, and level of care. Additionally, to provide Medical QA recommendations to ACSO leadership.		
Methodology	To provide Medical QA reviews for the reporting period, Forvis Mazars performed a medical record review of 15 incarcerated individual (patient) files to determine compliance with applicable requirements and community standards for appropriate access, timeliness, and continuity of care delivery for specified high-risk populations. A compliance score of less than 90-95% warrants a Corrective Action Plan (CAP). Areas at risk for non-compliance are also identified. *(See Appendix for Additional Methodology details)*		
Report Date	4/7/2025 (DRAFT) 4/23/2025 (FINAL)	**Reporting Period**	2/1 – 2/28/2025

ACTIVITIES PERFORMED BY PROJECT TEAM

- Submitted January 2025 Quality Assurance final report.
- Attended weekly scheduled Multi-Disciplinary meetings.
- Attended monthly MAC meeting.
- Attended monthly Suicide Prevention meeting.
- Received and reviewed reports for the reporting period.
- Conducted applicable monthly medical record QA and Continuous Quality Improvement (CQI) reviews.

PROJECT SCHEDULE

- Upcoming On-site Clinical Observation Dates:
  - April, May, June 2025 dates pending

COMMENDATIONS

- As reported in the Wellpath MAC Meeting:
  - Save of stroke patient 2/23/2025.
  - California Department Health Care Services (DHCS) audit with Adult Forensic Behavioral Health (AFBH).

SUMMARY

For the reporting period of 2/1 – 2/28/2025, Forvis Mazars Medical QA review identified opportunities for improvement (Observations) for the Clinical Team (Wellpath) to assure the delivery of quality care focusing on the following areas, in accordance with applicable National Commission on Correctional Health Care (NCCHC) standards: Governance and Administration, Patient Care and Treatment, Special Needs and Services, Medical: Legal Issues.

Onsite Clinical Observations are also provided in this report and include opportunities to improve compliance with quality assurance standards, medical and applicable policies, and/or applicable regulations. Areas at risk for non-compliance, including collaborative management and information sharing across different teams and systems, and adequacy of clinical staffing are also identified.

Forvis Mazars shall issue a formal Correction Action Plan (CAP) every quarter informed by the ongoing identified areas of noncompliance within the monthly reviews.

Demonstrated Areas of Improvement	
Compliance rate of greater than 90-95%.	**Increase in compliance rate of 20% or greater.**
8. Patients With Chronic Disease & Other Special Needs.	**3.** Receiving Screening 5. Nonemergency Health Care Requests & Services 6. Continuity, Coordination, & Quality of Care 8. Patients With Chronic Disease & Other Special Needs.

Areas of Risk	
Compliance rate of 0%.	2. Grievance Process for Health Care Complaints. 9. Restraint, Seclusion & Segregated Inmates. 10. Informed Consent & Right to Refuse.
Compliance rate of less than 90%.	**Decrease in compliance rates of 20% or greater.**
1. Access to Care. 2. Grievance Process for Health Care Complaints. 3. Receiving Screening. 4. Initial Health Assessment. 5. Nonemergency Health Care Requests & Services. 6. Continuity, Coordination, and Quality of Care. 7. Discharge Planning. 9. Restraint, Seclusion & Segregated Inmates. 10. Informed Consent & Right to Refuse.	9. Restraint, Seclusion & Segregated Inmates.
Identified areas at risk for non-compliance which require collaborative management and information sharing across different teams and systems.	**Identified areas at risk for non-compliance which require clinical staffing management to ensure prescriber and nursing time adequate to meet patient care delivery needs.**
1. Access to Care. 2. Grievance Process for Health Care Complaints. 3. Receiving Screening. 5. Nonemergency Health Care Requests & Services. 6. Continuity, Coordination & Quality of Care. 7. Discharge Planning. 8. Patients With Chronic Disease & Other Special Needs. 9. Restraint, Seclusion & Segregated Inmates. 10. Informed Consent & Right to Refuse.	3. Receiving Screening. 4. Initial Health Assessment. 5. Nonemergency Health Care Requests & Services. 6. Continuity, Coordination & Quality of Care. 7. Discharge Planning. 8. Patients With Chronic Disease & Other Special Needs. 9. Restraint, Seclusion & Segregated Inmates. 10. Informed Consent & Right to Refuse.

MEDICAL QUALITY ASSURANCE MONTHLY RESULTS REPORT

MEDICAL RECORD REVIEW: RESULTS

NCCHC Standard (E) = Essential (I) = Important	*Prior Month*	*Current Month*			
	Percentage Compliant *goal 90-95%**	**Files Compliant**	**Applicable Files Reviewed**	**Percentage Compliant** *goal 90-95%**	**Details for Non-Compliant Files**
** The compliance threshold goal for QA review is consistent with the compliance threshold for the related CQI studies. See Appendix for details.*					
I. Section A – Governance and Administration					
1. Access to Care A-01 (E) **Captured in QA CAP response evaluation.*	13.3%* (2/15)	1	15	6.7% (1 of 15)	14 of 15 files non-compliant: Patient 1: "Serious Mental Illness (SMI)," "ADA/Special Needs." Patient 2: "Unspecified psychosis," "Bipolar Disorder." Patient 3: No Mental Health diagnoses for prescribed anti-depressant medications (Mirtazapine). Patient 4: No Mental Health diagnoses for prescribed anti-psychotic (Risperidone) and anxiolytic (Buspirone) medications. Patient 5: "Onychomycosis," "Neuropathy Lower Extremity," "Lower Tier/Lower Bunk," "Gout," "Urinary Tract Infection," "Latent Syphilis." No Mental Health diagnoses for prescribed anti-psychotic medications (Haloperidol). Patient 6: None listed. "SMI." No Mental Health diagnoses for prescribed anti-psychotic (Haloperidol) and anti-tremor (Benztropine Mesylate) medications. Patient 7: "Palming/Hoarding/Cheeking pills." No Mental Health diagnoses for prescribed anti-depressant medications (Mirtazapine). Patient 8: "Syphilis," "Human Papilloma Virus." Patient 9: "Seizures," "Self-Harm Behavior/Self-Injury," "Suicide Watch," "Hypertension," "Adjustment Disorder with Mixed Disturbance of Emotions and Conduct." Patient 10: "Short Bowel Syndrome," "Anxiety," "Lower Level/Lower Bunk.". Patient 11: "Left Foot Drop," "Mobility Impairment – Restriction: Wheelchair use," "Other Chronic Osteomyelitis- Right Ankle and Foot." Patient 13: "SMI." Patient 14: "SMI," "Schizoaffective Disorder." Patient 15: "Left Finger Abscess," "Palming/Cheeking/Hoarding Pills." Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems.
2. Grievance Process for Health Care Complaints A-10 (I)	0.0% (0 of 2)	0	3	0% (0 of 3)	3 of 3 files non-compliant: Patient 10: Untimely resolution of grievance due to delayed coordination between custody and medical (18 days). No evidence of clinical documentation to address the created task. Patient 11: Grievance resolution delays, requiring multiple updates from Wellpath.

MEDICAL RECORD REVIEW: RESULTS

NCCHC Standard (E) = Essential (I) = Important	*Prior Month*	*Current Month*			
	Percentage Compliant *goal 90-95%**	**Files Compliant**	**Applicable Files Reviewed**	**Percentage Compliant** *goal 90-95%**	**Details for Non-Compliant Files**
					Multiple inconsistencies were identified in the documented care, including: (i) Incorrect information provided regarding the timeliness of neurological assessments. Inconsistent documentation of neurological checks and either no evidence or delayed scanning of related patient refusal. Additionally, despite the refusal, there was no evidence of cell-side neurological assessment. (ii) Multiple X-ray tasks delayed and rescheduled without explanation. Related patient refusals for physical therapy (PT) and Orthopedic specialty consults documented with no evidence of patient refusal forms scanned showing patient was informed of potential health risks associated with refusals. Inconsistent care coordination for medically necessary orthopedic shoe chrono. (iii) Inconsistent medication administration due to "out of stock" and "pharmacy closed" issues. Patient 12: Untimely resolution of grievance due to delayed coordination between custody and medical (17 days). Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems (i.e., Inmate Grievance Form, resolution, investigation, response).
II. Section E – Patient Care and Treatment					
3. Receiving Screening E-02 (E)	40.0% (6 of 15)	11	15	73.3% (11 of 15)	4 of 15 files non-compliant: Patients 1, 3, 6, 10: Receiving Screening/Abbreviated Receiving Screening not started timely. Completed beyond 8-hours from applicable Book-In time. Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems. *Requires clinical staffing management to ensure nursing time adequate to meet patient care delivery needs.
4. Initial Health Assessment E-04 (E) **Captured in QA CAP response evaluation.*	23.1% (3/13)	4	14	28.6% (4 of 14)	10 of 14 files non-compliant: Patients 4, 8, 11: IHA performed beyond the required 14-calendar days of the patient's Book-In. Patients 1, 3, 7, 14: No evidence of IHA. "Not Started" with no evidence or untimely scanning of related patient refusal. Patients 2, 6, 12: No evidence of hands-on physical exam performed within the required 14-calendar days of the patient's Book-In. Risk for non-compliance:

MEDICAL RECORD REVIEW: RESULTS

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	Percentage Compliant *goal 90-95%**	**Files Compliant**	**Applicable Files Reviewed**	**Percentage Compliant** *goal 90-95%**	**Details for Non-Compliant Files**
					*Requires clinical staffing management to ensure prescriber and nursing time is adequate to meet patient care delivery needs.
5. Nonemergency Health Care Requests & Services E-07 (E) **Captured in QA CAP response evaluation.*	20.0%* (1 of 5)	5	11	45.5% (5 of 11)	6 of 11 patients with Sick Call Requests > or = 50% with "Nursing Assessment(s)" performed beyond the required 24-hours from initial receipt. Review was limited to patient Sick Call Requests of 100 for each patient, as applicable. Patient 1: (2 of 2) Nursing Assessments performed beyond 24-hours from initial receipt of patient Sick Call Request. Patient 3: (6 of 9) Nursing Assessments performed beyond 24-hours from initial receipt of patient Sick Call Request. Patient 4: (1 of 1) Nursing Assessments performed beyond 24-hours from initial receipt of patient Sick Call Request. Patient 7: (3 of 6) Nursing Assessments performed beyond 24-hours from initial receipt of patient Sick Call Request. Patient 12: (2 of 2) Nursing Assessments performed beyond 24-hours from initial receipt of patient Sick Call Request. Patient 13: (1 of 2) Nursing Assessments performed beyond 24-hours from initial receipt of patient Sick Call Request. Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems. *Requires clinical staffing management to ensure prescriber and nursing time is adequate to meet patient care delivery needs.
6. Continuity, Coordination, & Quality of Care E-09 (E)	13.3% (2/15)	5	15	33.3% (5 of 15)	10 of 15 files non-compliant: Patient 2: Incomplete Return from Off-Site Care Visit documentation for continuity and care coordination. Patient 3: Delayed X-rays and Laboratory tests – multiple tasks rescheduled without explanation, incomplete and untimely scanning of related patient refusals. Patient 5: Inconsistent documentation for medication administration, with no evidence of provider sick call (PSC) task initiated to address medication compliance for existing chronic conditions. Delayed X-rays and Laboratory tests – multiple tasks rescheduled without explanation, incomplete and untimely scanning of related patient refusals. No evidence of task created for diabetic eye exam. Patient 6: Delayed Chest X-ray – multiple tasks rescheduled without explanation, incomplete and untimely scanning of related patient refusals.

MEDICAL RECORD REVIEW: RESULTS

NCCHC Standard (E) = Essential (I) = Important	*Prior Month*	*Current Month*			
	Percentage Compliant *goal 90-95%**	**Files Compliant**	**Applicable Files Reviewed**	**Percentage Compliant** *goal 90-95%**	**Details for Non-Compliant Files**
					Patient 10: No evidence PSC task initiated to address medication compliance for existing chronic condition. Delayed provider intervention to dietary order recommendation made by Registered Dietician. Inconsistent orders for lower bunk/lower level for patient risk for falls. Patient 11: Delayed X-rays – multiple tasks rescheduled without explanation, incomplete and untimely scanning of related patient refusals. Critical medications not initiated timely, contributing to unmanaged pain and withdrawal symptoms. Multiple patient refusals for physical therapy (PT) and Orthopedic specialty consults documented with no evidence of patient refusal forms scanned showing patient was informed of potential health risks associated with refusals. Patient 12: Inconsistent blood sugar monitoring. Inconsistent and incomplete documentation of nursing medication administration. Delayed X-rays – multiple tasks rescheduled without explanation, incomplete and untimely scanning of related patient refusals. Patient 13: Inconsistent Synthetics monitoring, with no evidence of cell-side nursing assessment when patient refused. Incomplete patient refusals for Laboratory tests documented with no evidence of patient refusal forms scanned showing patient was informed of potential health risks associated with refusals. Patient 14: Inconsistent Synthetics monitoring, with no evidence of cell-side nursing assessment when patient refused. Patient 15: No evidence COWS monitoring implemented, with no evidence of cell-side nursing assessment when patient refused. Incomplete Return from Off-Site Care Visit documentation and medication management for continuity and care coordination. Risk for non-compliance: *Multiple “Mental Health” referrals with no medical record visibility of consultation completion and related outcome. *Requires collaborative management and information sharing across different teams and systems. *Requires clinical staffing management to ensure prescriber and nursing time is adequate to meet patient care delivery needs.
7. Discharge Planning E-10 (E)	50.0% (7/14)	5	10	50.0% (5 of 10)	5 of 10 files non-compliant: Patients 2, 6, 10: No “Discharge Planner” (DP) task created. Patient required DP consult. Consult delayed (> 60 days), still in-house. Patient 3, 7: “Discharge Planner” consult delayed (> 90 days), still in-house.

MEDICAL RECORD REVIEW: RESULTS

NCCHC Standard (E) = Essential (I) = Important	*Prior Month*	*Current Month*			
	Percentage Compliant *goal 90-95%**	**Files Compliant**	**Applicable Files Reviewed**	**Percentage Compliant** *goal 90-95%**	**Details for Non-Compliant Files**
					Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems. *Requires clinical staffing management to ensure prescriber and nursing time is adequate to meet patient care delivery needs.
III. Section F – Special Needs and Services					
8. Patients With Chronic Disease & Other Special Needs F-01 (E)	55.6% (5/9)	6	6	100% (6 of 6)	Compliant. Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems. *Requires clinical staffing management to ensure prescriber and nursing time is adequate to meet patient care delivery needs.
IV. Section G – Medical: Legal Issues					
9. Restraint, Seclusion & Segregated Inmates G-01 & G-02 (E)	33.3% (2/6)	0	1	0% (0 of 1)	1 of 1 file non-compliant: Patient 9: Inconsistent or missing evidence of patient monitoring for current risk for self-harm behavior/self-injury (e.g., Suicide Ideation, Suicide Attempt, Suicide Watch). Risk for non-compliance: Patients 1, 13: Inconsistent alerts and coordination with multidisciplinary teams for patient at risk for self-harm behavior/self-injury. *Requires collaborative management and information sharing across different teams and systems. *Requires clinical staffing management to ensure prescriber and nursing time is adequate to meet patient care delivery needs.
10. Informed Consent & Right to Refuse G-05 (I)	0% (0/9)	0	6	0% (0 of 6)	0 of 6 files non-compliant: Inconsistent “Medication Refusal” forms for scheduled medication(s) on multiple dates as required per policy requirements (HCD-110_G-05) and inconsistency with refusal details documented on MAR (“Deputy body camera”). Patient 2: OLANZAPINE. Patient 4: RISPERIDONE, BUSPIRONE HCL. Patient 5: EMPAGLIFLOZIN, LOSARTAN POTASSIUM, METFORMIN HCL, UMECLIDINIUM. Patient 6: BENZTROPINE MESYLATE, HALOPERIDOL. Patient 10: VITAMIN B12, FIBER-LAX, FERROUS SULFATE. Patient 14: DIVALPROEX SODIUM, HALOPERIDOL. Risk for non-compliance: *Requires collaborative management and information sharing across different teams and systems

MEDICAL RECORD REVIEW: RESULTS

NCCHC Standard (E) = Essential (I) = Important	*Prior Month*	*Current Month*			
	Percentage Compliant *goal 90-95%**	**Files Compliant**	**Applicable Files Reviewed**	**Percentage Compliant** *goal 90-95%**	**Details for Non-Compliant Files**
					*Requires clinical staffing management to ensure prescriber time adequate to meet patient specialty care delivery needs

MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS DETAILS

I. Section A – Governance and Administration

1. Access to Care A-01 (E) Are the relevant problems/alerts appropriately identified?	Observation: Problem Lists, including both medical and behavioral health conditions, were not consistently started, completed, or up to date for most of the applicable patient files reviewed. Problems Lists limited to medical conditions only indicate improved compliance. Access to care means that the patient is seen by a qualified health care professional, is rendered an appropriate clinical judgment, and receives care that is ordered. Complete and accurate problem lists, as well as clinically indicated alerts, help eliminate intentional and unintentional barriers to care access and delivery. Clinically relevant acute and chronic diseases, such as, but not limited to, "Short Bowel Syndrome," "Seizure Disorder," "Other Chronic Osteomyelitis," "Left Foot Drop," "Hypertension," were not listed on the Problem List. Additionally, patients with prescribed atypical antipsychotic and antidepressant medications had no corresponding mental health diagnoses identified. Clinically indicated Alerts such as "Palming/Cheeking/Hoarding Pills – Diversion," "Suicide Watch," "Suicide Alert," "Serious Mental Illness," were inconsistently added for some of the applicable patient files reviewed. Care coordination and collaborative management across the different teams are required, to assure all patient Problems and Alerts, including medical and behavioral health, are identified, and managed appropriately. Without a complete and accurate Problem List and Alert Ribbon, there is an increased risk for inadequate care, inappropriate care, and delayed care, which could result in patient injury and/or harm.
2. Grievance Process for Health Care Complaints A-10 (I) Is the inmate grievance(s) timely, based on principles of adequate medical care, and supporting documentation?	Observation: The grievance process is measured against the principles of adequate and timely medical care and complete supporting documentation. Forvis Mazars observed untimely resolution of grievance due to delayed coordination between custody and medical as well as no evidence of clinical documentation to address the created task. Forvis Mazars also observed multiple inconsistencies were identified in the documented care, including: (i) Incorrect information provided regarding the timeliness of neurological assessments. Inconsistent documentation of neurological checks and either no evidence or delayed scanning of related patient refusal. Additionally, despite the refusal, there was no evidence of cell-side neurological assessment. (ii) X-ray tasks delayed and rescheduled without explanation. Related patient refusals for physical therapy (PT) and Orthopedic specialty consults documented with no evidence of patient refusal forms scanned showing patient was informed of potential health risks associated with refusals. Inconsistent care coordination for medically necessary orthopedic shoe chrono. (iii) Inconsistent medication administration due to "out of stock" and "pharmacy closed" issues. A comprehensive approach to address patient grievances helps ensure the patient concerns are addressed holistically, and that care is well-coordinated, which is particularly important for patients with comorbid conditions.

Governance and Administration Recommendation:

Process:

- Continue Corrective Action Plan (CAP) implementation to ensure compliance with problem lists and alerts, as outlined in Wellpath CAP response:
  - ITR training guidelines.
  - Nursing checklists.
  - Provider checklists.
  - CQI review to measure performance.
- Continue Improvement Plan implementation to:
  - Refine multidiscipline grievance processes to minimize information gaps, duplicative work, and ensure timely resolution.
  - Formalize and socialize updated grievance process, including new staff involvement, streamlined triage, time frames, and escalation process with inmates and all teams, as applicable.
  - Ensure Wellpath policy and procedure are in alignment with the ACSO and updated annually.
  - Redesign the Grievance process to ensure timely access to care and mitigate risk for delayed care. Wellpath and ACSO designees align policy and procedures and update annually. At a minimum, the grievance policy must include a timeframe for response, process for appeal, in accordance with applicable state and accreditation requirements.
  - Implement low-cost technology solution Robotics Processing Automation (RPA) to eliminate manual entry and operational waste.
- Continue to include the Grievance Process as a part of the CQI Program:
  - Track and trend grievances to identify recurrent issues and implement corrective action if indicated.
  - Ensure grievances are reviewed annually at a minimum, however Forvis Mazars recommends more frequent intervals if a trend is identified.
- Continue to review documentation against any related video surveillance to investigate grievance information gaps, as applicable.

MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS DETAILS

- Develop and implement workflow checklists and standardized practices (i.e., chronic, and/or new problems/diagnoses and alerts, pathophysiological states, potentially significant abnormal physical signs and laboratory findings, disabilities, and/or unusual conditions), and include relevant clinical information from outside facility and hospital medical clearance/discharge summaries.
- Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, AFBH behavioral health, and Maxor pharmacy, to uniformly manage and share information across teams and systems.
- Reassess clinical staffing plan to ensure prescriber and nursing time is sufficient to meet patient care delivery needs.

Technology:

- To eliminate clinically relevant information gaps and help mitigate human error from manual entry, work closely with Wellpath Corporate IT to submit relevant change requests timely to configure existing CorEMR modules and controls.
- Implement enhanced data integration solution(s) for bidirectional information sharing across applicable systems beyond current interfaces, between Wellpath medical (CorEMR), ACSO corrections (ATIMS), Adult Forensic Behavioral Health (AFBH) behavioral health (Gateway), and Maxor pharmacy (Guardian).

II. Section E – Patient Care and Treatment	
3. Receiving Screening E-02 (E) Is the receiving screening form completed appropriately and timely?	Observation: While there is improvement from the prior month, some of the applicable patient files reviewed showed inconsistent and delayed Intake/Admission Screening documentation beyond 8-hours from the applicable Book-In time. Receiving Screening should be performed as soon as possible on all inmates upon arrival at intake to ensure that emergent and urgent health needs are met. Appropriate and timely receiving screening intends to identify potential emergency situations among new arrivals and ensures that patients with known illnesses and those on medications are identified for further assessment and continued treatment. Use of screening forms excluding mental health details, including documentation referring to the AFBH clinician's responsibility to perform the mental health section of the screening, or scanned AFBH "Assessment Initial Brief" document was not consistent. Without appropriate, timely, up to date, and consistent Receiving Screening assessments, the Clinical Team cannot establish an adequate and individualized care plan to responsibly care for the patient, identify and assure patient health care needs are met, and meet applicable policy, procedure, and standards requirements.
4. Initial Health Assessment E-04 (E) Is the IHA completed within 14 calendar days? If not, is the patient refusal form completed correctly and timely?	Observation: Evidence of compliance with the requirement to initiate and/or complete the IHA or a hands-on physical exam within 14-calendar days of a patient's intake to the facility was missing, untimely, or inconsistent (i.e., Health Appraisal scheduled or completed without documented evidence). For more than half of the applicable patient files reviewed, there was no documented evidence of an IHA, or a hands-on physical exam being scheduled or completed. According to Wellpath's updated IHA Workflow (updated 12/10/2024), a hands-on physical exam component has been added to the Receiving Screening process. At a minimum, the hands-on physical exam must be scheduled for the 5th day of incarceration and completed no later than 14-calendar days from applicable Book-In. The hands-on physical exam and completion of the Receiving Screening form replaces the traditional IHA form to meet compliance with NCCHC's requirements. All inmates should receive Initial Health Assessments (IHA). Additionally, evidence of related scanned patient refusals was not consistent. Without a complete and/or timely initial medical history and physical exams, the Clinical Teams cannot establish an appropriate and individualized care plan to responsibly care for the patient, appropriately identify and assure patient health care needs are met, and meet applicable policy, procedure, and standards requirements.
5. Nonemergency Health Care Requests & Services E-07 (E) Is there evidence that the patient was seen within 24 hours of the patient sick call request?	Observation: While there is improvement from the prior month, Nursing Assessments related to patient health care/sick call requests were not consistently timely for some of the applicable patient files reviewed – patients were classified as non-compliant if half or more (>= 50%) of the nursing assessments reviewed were performed beyond the required 24-hour turnaround time, per applicable policies. All patient nonemergent health care needs should be met and prioritized. All inmates, regardless of housing, should be given the opportunity to submit health care/sick call requests. Additionally, some of the patient Sick Call Requests continue to be miscategorized and not consistently named. Inability to respond timely and document the date the assessment and related care was provided, and/or inconsistent naming convention increases the risk of inadequate care, inappropriate care, delayed care, and uncoordinated care, which could negatively impact patient outcome(s) and result in patient injury and/or harm.
6. Continuity, Coordination, & Quality of Care E-09 (E)	Observation: While there is improvement from the prior month, continuity, coordination, and quality of care was inconsistent for some of the patient files reviewed, some of which can be considered a near miss, defined as an event that could have resulted in harm to a patient but was prevented before reaching the patient through intervention or by chance. Additionally, a minor error if the patient experienced preventable symptoms but did not suffer

Is patient medical, dental, and mental health care coordinated and monitored from admission to discharge?	serious harm. The delivery of coordinated care, such as continuity of care upon "Return from Off-Site Care Visit," completion of laboratory tests and radiology imaging, medication reconciliation and administration, and psychiatric care, were inconsistent or delayed for some of the applicable patient files reviewed. Patient refusals for healthcare services were inadequately documented by deferring to the "Deputy body camera" without scanned patient refusal form documentation. Documentation showed delays in performing laboratory tests and X-rays for symptomatic presentations (e.g., chest pain, hip mass). Several patient files reviewed showed inconsistent medication management, where medication orders and administration were delayed or missed. Mental Health referral outcomes were visible within CorEMR but Return from Off-Site Care Visit documentation remained inconsistent. The inability to provide appropriate and timely care in accordance with community clinical standards and guidelines, increases the risk for inadequate care, inappropriate care, delayed care, and uncoordinated care, which could negatively impact patient outcome(s) and result in patient injury and/or harm. Patient medical, mental health, and specialty care should be coordinated and monitored from Book-In to release. The inability to provide adequate transitional care in accordance with community clinical standards and guidelines, increases the risk for inadequate care, inappropriate care, delayed care, and uncoordinated care, which could negatively impact patient outcome(s) and result in patient injury and/or harm.
7. Discharge Planning E-10 (E) Is discharge planning provided for inmates with serious health needs?	Observation: Discharge Planning consults were inconsistent or delayed for some of the applicable patient files reviewed. Discharge planning should be provided for patients with serious health needs, including making formal linkages between the facility and community-based organizations (CBO), lists of community health professionals, discussions with patients that emphasize the importance of appropriate follow-up and aftercare, appointments and medications arranged for the patient at release, and timely exchange of health information. The inability to provide adequate discharge planning in accordance with industry standards and best practice increases the risk for inadequate care, inappropriate care, delayed care, and uncoordinated care, which could negatively impact patient outcome(s) while incarcerated and when released into the community, and result in patient injury and/or harm.

Patient Care and Treatment Recommendation:

Process:

- Continue CAP implementation to ensure compliance with hand-on physical examination within the required 14-day timeframe, as outlined in Wellpath CAP response and updated IHA Workflow (updated 12/10/2024):
  - History and Physical process development and enhancement.
  - Staff training.
  - CQI review to measure performance.
- Continue CAP implementation to ensure compliance with the nonemergency health care requests for services, as outlined in Wellpath CAP response:
  - Medical request process development and enhancement.
  - Staff training.
  - CQI review to measure performance.
- Continue Improvement Plan implementation to:
  - Consistently perform complete Receiving Screening assessments appropriately and timely, as required at intake, with the use of checklists and updated screening forms. In the event a Receiving Screening is not possible, require justification documentation and the timely completion of an Abbreviated Receiving Screening form.
  - Require appropriate and timely care delivery to meet community clinical standards and guidelines, including the review of case studies with the Clinical Team as a part of continuous improvement activities.
  - Require the delivery of timely, coordinated discharge planning, including California Advancing and Innovating Medi-Cal (CalAIM) initiatives, as required by policy and best practice, in collaboration with the multidisciplinary teams.
  - Develop a list of justification reasons to reschedule an appointment, socialize, and implement across all disciplines.
  - Assure health evaluation and treatment refusal protocol described in HCD-110_G-05 Informed Consent and Right to Refuse policy is followed, including real-time communication and documentation.
- Hold Clinicians accountable for the notification, delivery, and documentation of medically necessary care.
- Provide additional focused staff training and education, as applicable.
- Perform ongoing internal review and monitoring of care delivery appropriateness, timeliness, and care coordination, as well as Sick Call follow-up and clinical Tasks, as applicable. Consider including it in the existing Provider chart review process. Report results of review and monitoring to ACSO.
- Continue multi-disciplinary partnerships to improve care coordination, including medication reconciliation: Wellpath medical, ACSO corrections, and AFBH behavioral health, to uniformly manage and share information across teams and systems.
- Reassess clinical staffing plan to ensure prescriber and nursing time is sufficient to meet patient care delivery needs.

Technology:

- To eliminate clinically relevant information gaps and help mitigate human error from manual entry, work closely with Wellpath Corporate IT to submit relevant change requests timely to configure existing CorEMR modules and controls.
- Implement enhanced data integration solution(s) for bidirectional information sharing across applicable systems beyond current interfaces, between Wellpath medical (CorEMR), ACSO corrections (ATIMS), Adult Forensic Behavioral Health (AFBH) behavioral health (Gateway), and Maxor pharmacy (Guardian).

III. Section F – Special Needs and Services	
8. Patients With Chronic Disease & Other Special Needs F-01 (E) Is the patient with chronic disease assessed at least every 90 days with an updated treatment plan?	Criteria met.

Special Needs and Services Recommendation:

Process:

- Continue Improvement Plan implementation to:
  - Require appropriate and timely care delivery, include the review of case studies with the Clinical Team as a part of continuous improvement activities.
  - Require the delivery of timely, coordinated chronic care and special needs services in collaboration with the multidisciplinary teams.
  - Develop a list of justification reasons to reschedule an appointment, socialize, and implement across all disciplines.
  - Hold Clinicians accountable for the notification and delivery of medically necessary care.
  - Continue to provide additional focused staff training and education to assure the appropriate services are provided and define individual care plans.
  - Perform ongoing internal review and monitoring of care delivery appropriateness, timeliness, care coordination, as well as Sick Call follow-up and clinical Tasks, as applicable.
  - Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, AFBH behavioral health, and Maxor pharmacy, to uniformly manage and share information across teams and systems.
  - Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs.

Technology:

- Work closely with Wellpath Corporate IT to submit relevant change requests timely to enhance existing CorEMR automation to populate relevant documentation within the applicable forms and/or MAR.
- Implement enhanced data integration solution(s) for bidirectional information sharing across applicable systems beyond current interfaces, between Wellpath medical (CorEMR), ACSO corrections (ATIMS), Adult Forensic Behavioral Health (AFBH) behavioral health (Gateway), and Maxor pharmacy (Guardian).

IV. Section G – Medical: Legal Issues	
9. Restraint and Seclusion & Segregated Inmates G-01 & G-02 (E) For the patient at risk for self-harm, was health monitoring initiated timely, and continued at medically appropriate intervals?	Observation: One patient file reviewed showed inconsistent alerts, coordination with multi-disciplinary teams, and use of patient monitoring Flow Sheets as indicated for the risk of patient Self-Harm Behavior/Self-Injury. Segregated patients should be monitored timely, at initiation and at continued medically appropriate intervals to assure the patient is not harmed by the intervention. Any practice of restraint, seclusion, and segregation should not adversely affect a patient's health. Delay or inconsistent initiation of patient monitoring Flow Sheets, including "Sobering/Safety/Restraints" or "Nursing Segregated Population Rounding Log" Flow Sheets, when the patient requires close monitoring for Suicide Attempt, Suicidal Ideation, or Suicide History, increases the risk for a safety incident, including patient injury and/or harm. Further, the multidisciplinary teams cannot evidence compliance with policies (8.12 Inmate Observation and Direct Visual Supervision; 8.13 Safety Cells, Temporary Holding Cell, and Multipurpose Rooms; HCD-110_G02 Segregated Inmates), and applicable standards.
10. Informed Consent & Right to Refuse G-05 (I) If the patient refuses medications, did the refusal documentation include evidence that the patient has been informed and understands any adverse health consequence that may occur because of refusal?	Observation: All of the applicable patient files reviewed showed inconsistency and/or missing required patient refusal forms for medication administration. Inmates have the right to make informed decisions regarding health care, including the right to refuse. Forvis Mazars found that some of the patient files reviewed showed inconsistency in the scanning of patient medication refusals for chronic medication management, specifically missing medication refusals or scanning delays beyond 48-hours, contributing to medication inconsistencies with the MAR. Without complete and timely scanning of priority medical records, such as patient medication refusals, the Clinical Teams cannot responsibly identify a pattern of refusal and follow established refusal policy and protocol, *HCD-110_G-05 Informed Consent and Right to Refuse*, to manage the risk factors for medication nonadherence. Policy outlines that "In the case of medication refusals, in addition to a signed refusal form, documentation on the MAR will indicate the patient refused the medication. For Scheduled Routine Medications: If a patient

	misses four doses in a seven-day period, or establishes a "pattern of refusal," the patient is referred to the prescribing Provider. The referral is submitted after the fourth missed dose. For High-Priority Medications: Health care staff shall make contact (must be documented) with a patient on a High-Priority Medication who does not show to medication pass in order to check patient status and obtain a refusal. Patient will be educated on the dangers of missed medication. If a patient refuses or misses a High-Priority Medication, the patient is referred to the prescribing provider for chart review and the determination of the need for a face-to-face encounter." Examples of High-Priority Medications include Oxcarbazepine and Atenolol. Inconsistent medication management, including conflicting medication administration vs. patient refusal documentation and evidence, can lead to a medication error, such as a missed medication dose and result in patient injury, harm, and/or grievance. Additionally, without evidence of patient refusals to show that the patient was provided education and understands the risks involved with not being evaluated or treated, there is an increased risk for patient injury and/or harm, as well as organizational risk.

Medical: Legal Issues Recommendation:

Process:

- Continue Improvement Plan implementation to:
    - Require appropriate and timely care delivery, include the review of case studies with the Clinical Team as a part of continuous improvement activities.
    - Require timely patient assessment and monitoring as ordered and per policy, with supporting justification documentation if unable to execute.
    - Define, formalize, communicate, and implement enhanced patient observation, direct supervision, safety cell, and segregated population processes across the impacted teams and follow-up to assess implementation. Update policies and procedures accordingly.
    - Clearly align defined Level of Care considerations and interventions, as applicable, for patients requiring ongoing monitoring.
    - Assure medication refusal protocol described in HCD-110_G-05 Informed Consent and Right to Refuse policy is followed, including real-time communication and documentation.
- Hold Clinicians accountable for the notification, delivery, and documentation of medically necessary care.
- Provide additional focused staff training and education, as applicable.
- Continue to review documentation against any related video surveillance to investigate medication administration grievance information gaps, as applicable.
- Perform ongoing internal review and monitoring of care delivery appropriateness, timeliness, and care coordination, as well as Sick Call follow-up and clinical Tasks, as applicable. Consider including in the existing Provider chart review process. Report results of review and monitoring to ACSO.
- Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, and AFBH behavioral health, to uniformly manage and share information across teams and systems.
- Reassess clinical staffing plan to ensure prescriber and nursing time is sufficient to meet patient care delivery needs.

Technology:

- To eliminate clinically relevant information gaps and help mitigate human error from manual entry, work closely with Wellpath Corporate IT to submit relevant change requests timely to configure existing CorEMR modules and controls.
- Work closely with Wellpath Corporate IT to submit relevant change requests timely to enhance existing CorEMR automation to populate relevant documentation within the applicable forms and/or MAR.
- Implement enhanced data integration solution(s) for bidirectional information sharing across applicable systems beyond current interfaces, between Wellpath medical (CorEMR), ACSO corrections (ATIMS), Adult Forensic Behavioral Health (AFBH) behavioral health (Gateway), and Maxor pharmacy (Guardian).

ON-SITE CLINICAL VISIT(S): OBSERVATIONS AND RECOMMENDATIONS

V. Continuous Quality Improvement Activities Reconciliation

Observation: During the Clinical Observation onsite visit 2/26/2025 – 2/27/2025, Forvis Mazars met with Wellpath Quality Coordinator to reconcile outstanding Wellpath Continuous Quality Improvement (CQI) activities. This included a review of both initial evaluations and re-evaluation studies aligned with performance improvement plans.

V.1. Evidence:

- V.1.1. The new quality platform, Onspring, was reviewed. This platform is being implemented to better track critical clinical events and document CQI reviews, findings, and performance improvement plans in a centralized and structured format.
- V.1.2. All 2024 CQI re-studies that fall below the 90% compliance threshold will remain open and continue until compliance reaches or exceeds 90%.
- V.1.3. Questions from the 2025 CQI studies will be integrated into the ongoing 2024 re-studies. A minimum of 10 charts will be reviewed for each study to ensure data consistency and depth.
- V.1.4. If a 2024 CQI re-study aligns with a 2025 scheduled study, it will count as the initial 2025 study. This ensures efficient use of resources while maintaining continuity.
- V.1.5. When a 2024 re-study conducted in early 2025 reaches the 90% compliance threshold, no additional re-studies will be required for that cycle. However, if the same study is scheduled again for later in 2025, a new initial study will still be conducted per the 2025 plan.
- V.1.6. For 2025 CQI studies:
  - V.1.6.1. If the initial study meets or exceeds the 90% compliance threshold, no re-studies will be required.
  - V.1.6.2. A follow-up annual study will then be conducted in 2026.
  - V.1.6.3. A potential site-specific CQI study was discussed for 2025, focused on inconsistencies in the documentation of emergent medication administration on MAR (Medication Administration Record) entries.

V.2. Recommendations:

- V.2.1. Continue regular reconciliation of CQI activities and study findings between teams to:
  - V.2.1.1. Identify data discrepancies and trends early.
  - V.2.1.2. Ensure data accuracy and consistency.
  - V.2.1.3. Align team goals with quality and safety priorities.
  - V.2.1.4. Enhance accountability, transparency, and ownership of outcomes.
  - V.2.1.5. Strengthen risk management practices through proactive analysis.
  - V.2.1.6. Facilitate continuous process improvement and best practice adoption.
- V.2.2. Regular reconciliation of CQI activities and study findings, to ensure internal and external reviews are contributing to a unified strategy that drives measurable improvement in quality of care, operational efficiency, and patient safety.

APPENDIX

PROJECT DETAILS

Project Scope	Assess and evidence the County and ACSO compliance with complex requirements applicable to Alameda County's Santa Rita Jail (SRJ) adult correctional facility and to evaluate quality of care provided by Wellpath. Additionally, evaluate the County's compliance with applicable laws, rules, and regulations of applicable government authorities regarding the ambulatory medical care provided to incarcerated individuals (patients) at SRJ and required by the ACSO. Project scope excludes the provision of any direct patient medical care.

METHODOLOGY

A. MEDICAL QUALITY ASSURANCE MEDICAL RECORD REVIEW

As described in Exhibit A-1 of the Master Services Agreement (MSA), Forvis Mazars conducted monthly medical record review of patient medical records to evaluate the timeliness of care, appropriateness of assessment, treatment, type of Provider and level of care, within the specified populations and areas of focus. Forvis Mazars performed the following quality assurance related activities:

- Evaluated 15 patient files for the reporting period, as applicable:
  - Death: Patient death/mortality.
  - Suicide: Patients who attempted suicide, with history of suicide, or reported suicidal ideation.
  - Hospital Transport and Admission: Patients emergently transported to a hospital for evaluation, and/or inpatient admission, and/or for an Outpatient Specialist appointment.
  - Grievances: Patients with medical grievances.
  - Women's Health, OBGYN Services: Female patients under Women's Health, OBGYN care.
- Tested patient files against compliance indicators, such as, but not limited to, access, appropriateness, continuity, and timeliness of care delivery, and compliance with applicable requirements and evidence-based best practice, including, but not limited to facility and medical policies and procedures, National Commission on Correctional Health Care (NCCHC), American Correctional Standards (ACA), California Code of Regulations, and community standards of care.
- Compliance indicators are as follows:
  1. **Access to Care** – Are the relevant problems/alerts appropriately identified?
  2. **Grievance Process for Health Care Complaints** – Is the inmate grievance(s) timely, based on principles of adequate medical care, and supporting documentation?
  3. **Receiving Screening** – Is the receiving screening form completed appropriately and timely?
  4. **Initial Health Assessment** – Is the IHA completed within 14 calendar days? If not, is the patient refusal form completed correctly and timely?
  5. **Nonemergency Health Care Requests and Services** – Is there evidence that the patient was seen within 24 hours of the patient sick call request?
  6. **Continuity, Coordination, and Quality of Care** – Is patient medical, dental, and mental health care coordinated and monitored from admission to discharge?
  7. **Discharge Planning** – Is discharge planning provided for inmates with serious health needs?
  8. **Patients With Chronic Disease and Other Special Needs** – Is the patient with chronic disease assessed at least every 90 days with an updated treatment plan?
  9. **Restraint and Seclusion & Segregated Inmates** – For the patient at risk for self-harm, was health monitoring initiated timely, and continued at medically appropriate intervals?
  10. **Informed Consent and Right to Refuse** – If the patient refuses medications, did the refusal documentation include evidence that the patient has been informed and understands any adverse health consequence that may occur because of refusal?
- Performed clinical observations and provided corresponding observations and recommendations.

Additional considerations:

- For the medical quality assurance (QA) reporting period*, Forvis Mazars conducted medical record review of 15 incarcerated individual (patient) files for the specified high-risk populations and areas of highest concern, consistent with contract requirements. The files reviewed were limited to include the patients discussed during the weekly Multi-Disciplinary Round (MDR) meetings and patients selected from scheduled monthly reports including the suicide attempt report, the medical grievance report, the OBGYN Report, and the transportation/hospitalization report, for the specified reporting period.
  - *The "reporting period" refers to the month that patient files were selected from the specified populations and areas of focus noted above. To adequately evaluate timeliness of care, appropriateness of assessment, treatment, type of Provider and level of care, Forvis Mazars reviewed each patient's medical record booking from Book-In to Release. For patients that were determined to be in custody for multiple years, intake details, care provided during the current year, and release details were reviewed.

METHODOLOGY

- While the sample size of 15 is not statistically significant when compared to the overall population size, the sampling methodology is designed to select specified patient populations and areas of highest concern as identified within the MSA.

- Observations that overlap across multiple focus areas were considered non-compliant for the compliance indicator that most impacted patient care delivery; the observation was noted as a "Risk for non-compliance" for all other areas.
- The compliance threshold goal for QA review is consistent with the compliance threshold for the related CQI studies, as follows:
  - 90% compliance threshold goal:
    1. Access to Care.
    2. Grievance Process for Health Care Complaints.
    4. Initial Health Assessment.
    5. Nonemergency Health Care Requests and Services.
    7. Discharge Planning.
    9. Restraint and Seclusion & Segregated Inmates.
  - 95% compliance threshold goal:
    3. Receiving Screening.
    6. Continuity, Coordination, and Quality of Care.
    8. Patients With Chronic Disease & Other Special Needs.
    10. Informed Consent and Right to Refuse.
- A compliance score of less than 90-95% warrants a Corrective Action Plan (CAP). Areas at risk for non-compliance, requiring collaborative management and information sharing across different teams and systems, and adequacy of clinical staffing were also identified.
- Quality assurance not only measures compliance with standards and mitigates risk but also includes the follow-up on corrective action plan activities, facilitates accountability, and informs quality improvement processes. Forvis Mazars thereby identifies linkages between quality assurance and continuous quality improvement observations.

B. MINOR AND MAJOR ERROR(S)

To observe any minor or major error in medical care, Forvis Mazars performed the following activities, as applicable:

- Outlined the circumstances of the error.
- Proposed recommendations for corrective action.
- Follow-up on corrective action implementation, as applicable.

C. PATIENT DEATH(S), SUICIDE, AND ATTEMPTED SUICIDE

To review medical records for patient death(s), Forvis Mazars performed the following activities:

- Reviewed medical care provided to patient prior to death.
- Reviewed documentation, as applicable, following death, including 30-Day and 120-Day death reviews (Death review meetings)

To review medical records for patient(s) who were reported as having attempted suicides, Forvis Mazars performed the following activities:

- Reviewed occurrence of suicide attempt.
- Reviewed medical care provided following suicide attempt, including suicide prevention strategies and multidisciplinary care plan (Suicide Prevention meetings).

D. HOSPITAL TRANSPORT AND ADMISSIONS

To review medical records upon patient emergent transport to a hospital for evaluation, and/or inpatient admission, and/or Outpatient Specialist appointment, Forvis Mazars performed the following activities:

- Reviewed occurrence of a patient emergently transported to a hospital for evaluation.
- Reviewed occurrence when a patient is admitted to a hospital, including the circumstances leading to the inpatient admission.
- Reviewed occurrence when a patient is transported to an Outpatient Specialist appointment.

E. GRIEVANCE REVIEW

To evaluate patient medical grievances, Forvis Mazars performed the following activities:

- Reviewed select medical grievance claims for the applicable reporting period to identify larger, systemic medical concerns underlying grievance, as applicable.
- Included patients with medical grievance claims for the reporting period.

F. WOMEN'S HEALTH AND OBGYN SERVICES REVIEW

To evaluate the medical care of female patients, including Women's Health Clinic and OBGYN services, Forvis Mazars performed the following activities:

- Reviewed medical records of female patients under medical care for the reporting period.
- Reviewed medical records of female patients under care of OBGYN clinic in the report period.
- Evaluated compliance with all relevant regulations, standards, and agreements adopted by the ACSO.

G. ON-SITE CLINICAL OBSERVATION VISIT(S)

- Forvis Mazars performed clinical observation for the reporting period and provided related observation details and recommendations.
- As applicable, Forvis Mazars evaluated status of Wellpath medical initiatives not identified as site-specific CQI Studies and provided related observation details and recommendations.

H. CORRECTIVE ACTION PLAN

- As applicable, Forvis Mazars issued a Quality Assurance Corrective Action Plan (CAP) based on identified ongoing issues of non-compliant performance described within the Medical Quality Assurance Monthly Reports.
- QA CAP(s) shall be issued to Wellpath every quarter, as applicable.
- CAP definition, responsibilities, response, and escalation details are described in the Corrective Action Plan procedure and corresponding ACSO Memo.

I. OTHER

- Forvis Mazars provided third-party medical consultation to Wellpath and ACSO on medical issues including the review of medical records, diagnoses, and treatment plans, as well as discussion with those Clinicians providing direct care, as needed.
- Forvis Mazars provided guidance and recommendations, as necessary, related to medical facility licensure, accreditation, treatment protocols, and general medical quality assurance and continuous quality improvement issues.