CONTINUOUS QUALITY IMPROVEMENT MONTHLY RESULTS REPORT

PROJECT DETAILS

Name	Alameda County Sheriff Office – Medical Operations Consulting: Continuous Quality Improvement Program Review				
Sponsor	Lieutenant Joseph Atienza, Contracts Lieutenant			**Project Manager**	Tami Bond
Project Summary	To provide expanded Medical Quality Assurance (QA) services for the Alameda County Sheriff Office (ACSO) through the performance of Continuous Quality Improvement (CQI) program review and support to evaluate ongoing CQI monitoring activities, performance improvement strategies, and change implementation effectiveness. Additionally, to provide focused CQI observations and recommendations to help assure appropriate access, timeliness, and continuity of care delivery.				
Methodology	To provide CQI program and study review for the audit timeframe, Forvis Mazars performed medical record review of up to 24 incarcerated individual (patient) files against Wellpath's CQI criteria for the defined study outlined in the 2024 CQI calendar. Consistent with the Plan-Do-Study-Act (PDSA) model, Forvis Mazars performed medical record review after Wellpath's initial audit, subsequent implementation of related Improvement Plan and re-evaluation, to measure long-term performance of the improvement strategy. A compliance score of less than 90-95% threshold warrants a corrective action plan (CAP). *(See Appendix for additional Methodology and CQI program standard details)*				
Wellpath Study Date	9/2024	**Forvis Mazars Audit Timeframe Period**	11/1/2024 - 1/31/2025	**Date Report Sent**	2/19/2025 (DRAFT) 3/3/2025 (FINAL)
CQI Studies	Diabetes - HEDIS (Healthcare Effectiveness Data and Information Set)				

SUMMARY

For the audit timeframe of 11/1/2024 - 1/31/2025, Forvis Mazars CQI program and study review of the Diabetes-HEDIS* processes to determine recent change implementation effectiveness, identified additional opportunities for improvement (Observations) for the Clinical Team (Wellpath) to help assure appropriate access, timeliness, and continuity of care delivery. A total of five criteria (Questions) for Diabetes-HEDIS were measured.

Wellpath performed the following evaluation studies based on two CQI calendar years (2023 and 2024):

- 2023 – Two re-evaluations.
- 2024 – One initial, one re-evaluation.

Forvis Mazars identified recurring non-compliance with one criterion across all of Wellpath's re-evaluations in this key area:

- Documenting an examination of feet for neuropathy using a nylon filament annually on patients confined at least 12 months.

Wellpath May 2024 1st Re-evaluation study:
Based on Wellpath's 2023 CQI calendar, the initial Diabetes – HEDIS study was performed on September 27, 2023*, with a re-evaluation study on May 10, 2024, measuring five criteria. Wellpath scored an overall compliance rate of 72%. Consistent with the Study stage of the PDSA cycle, Wellpath was required to perform a re-evaluation of its Improvement Plan implementation due to not meeting the 90% compliance threshold for one criterion – Wellpath scored 56% on blood sugar monitoring. The re-evaluation was intended to measure the impact of the Action Step implementation that should have included educating the nursing staff and medical providers on monitoring blood sugars in accordance with the treatment plans.

**Reported in Forvis Mazars May 2024 CQI report.*

Wellpath July 2024 2nd Re-evaluation study:
The second Diabetes - HEDIS re-evaluation study was performed on July 29, 2024, measuring five criteria. Wellpath scored an overall compliance rate of 93%. Consistent with the Study stage of the PDSA cycle, Wellpath was required to perform a re-evaluation of its Improvement Plan implementation due to not meeting the 90% compliance threshold for one criterion – Wellpath scored 67% on the neuropathy foot assessment. The re-evaluation was intended to measure the impact of the Action Step implementation that should

have included educating the medical providers on performing annual examination of patient's feet for neuropathy using a nylon filament.

Wellpath November 2024 Initial Study:
Based on Wellpath's 2024 CQI calendar, the initial Diabetes – HEDIS study scheduled for September 2024 was not performed until November 7, 2024, measuring five criteria. Wellpath scored an overall compliance rate of 96%. Consistent with the Plan-Do-Study stage of the PDSA cycle, Wellpath was required to perform a re-evaluation of its Improvement Plan implementation due to not meeting the 90% compliance threshold for one criterion – Wellpath scored 60% on the neuropathy foot assessment. The re-evaluation was intended to measure the impact of the Action Step implementation that should have included educating the medical providers on performing annual examination of patient's feet for neuropathy using a nylon filament.

Wellpath January 2025 Re-evaluation study:
As part of the continuous improvement process, the Diabetes - HEDIS re-evaluation study was performed on January 20, 2025, measuring five criteria. Wellpath scored an overall compliance rate of 78%. Consistent with the Study stage of the PDSA cycle, Wellpath was required to perform a re-evaluation of its Improvement Plan implementation for multiple criteria not meeting the 90-95% compliance threshold. The re-evaluation was intended to measure the impact of the Action Step implementation that should have included educating the medical providers on performing annual examination of patient's feet for neuropathy using a nylon filament and performing annual eye exams and the nursing staff on reporting elevated blood pressure readings.

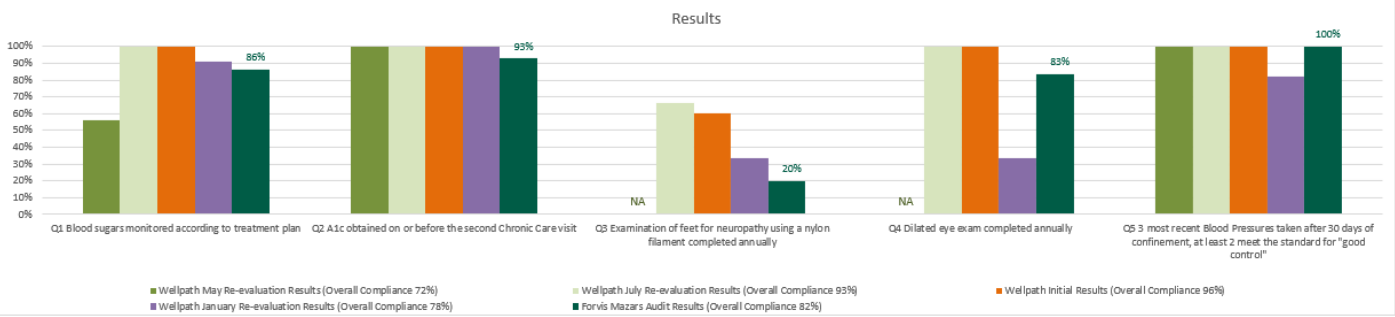
Forvis Mazars performed an annual medical record review that resulted in an overall compliance rate of 82%. Due to yielding a score less than the 90-95% threshold, consistent with the Act stage of the PDSA cycle, Forvis Mazars recommends implementing a CAP. This CAP should include enhanced action steps based on observations and recommendations provided, incorporate findings from Forvis Mazars' and include a subsequent re-evaluation within six months or more to demonstrate long-term change implementation effectiveness.

Areas of Risk:

i. Areas at risk for noncompliance identified to require operational efficiency to meet patient care delivery needs include:
   - Timely blood sugar monitoring is evidenced.
   - Timely lab draws.
   - Completed Annual Dilated Eye Exams.

**Reviewed in Medical QA reports Section E: Patient Care and Treatment – Continuity, Coordination, & Quality of Care E-09 (E).*

Diabetes-HEDIS



CONTINUOUS QUALITY IMPROVEMENT MONTHLY RESULTS REPORT

MEDICAL RECORD REVIEW: RESULTS

	Wellpath Re-Evaluation & Initial Reviews				***Forvis Mazars CQI Review Audit Timeframe Month***	
Date	*5/2024 (2023 1st Re-eval.)*	*7/2024 (2023 2nd Re-eval.)*	*11/2024 (Initial Eval.)*	*1/2025 (2024 Re-eval.)*	***2/2025***	
PDSA Model	Plan-Do-Study				**Act**	**Details for Non-Compliant Files**
Criteria	Percentage Compliant				**Percentage Compliant**	
	goal 90-95% (# compliant/# total applicable)					
1. Is there evidence that blood sugars are monitored in accordance with the treatment plan? [90% compliance]	56% (9/16)	100% (9/9)	100% (14/14)	91% (10/11)	86% (19/22)	3 of 22 files non-compliant: Patient 2: Inconsistent evidence of timely patient assessments at least every 90 days, or sooner in accordance with the treatment plan. Patient 13: Lab draws not consistently performed and completed, with multiple unexplained rescheduled appointments, resulting in delayed Chronic Care visits and treatment plans. Patient 15: Delayed Receiving Screening and order of medications (greater than 36 hours from applicable book-in time). Lab draw order tasks not consistently performed and completed, with multiple unexplained rescheduled appointments. Risk of non-compliance: Patients 13,18, 20, 21, 22: Lab draw order tasks not consistently performed and completed, with multiple unexplained rescheduled appointments, resulting in delayed Chronic Care visits and treatment plans. Patients 7, 8: No evidence of documentation demonstrating patients were seen by medical providers proactively for chronic care management; Psychiatrist lab draw order task prompted medical provider to initiate an initial chronic care visit.
2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract? [95% compliance]	100% (6/6)	100% (12/12)	100% (12/12)	100% (10/10)	93% (13/14)	1 of 14 files non-compliant: Patient 18: Delayed A1c lab draw task performed prior to second Chronic Care visit. Risk for non-compliance: Delay in care, where lab draw tasks were not consistently performed and completed, with multiple unexplained rescheduled appointments.
3. An examination of feet for neuropathy using a nylon filament is completed annually on	*NA*	67% (6/9)	60% (3/5)	33% (2/6)	20% (2/10)	8 of 10 files non-compliant: Patients 1, 2, 4, 5, 6, 7, 8, 13: No documented evidence of a nylon filament used annually as part of examination of the feet for neuropathy.

MEDICAL RECORD REVIEW: RESULTS						
	Wellpath Re-Evaluation & Initial Reviews				***Forvis Mazars CQI Review Audit Timeframe Month***	
Date	*5/2024 (2023 1st Re-eval.)*	*7/2024 (2023 2nd Re-eval.)*	*11/2024 (Initial Eval.)*	*1/2025 (2024 Re-eval.)*	***2/2025***	
PDSA Model	Plan-Do-Study				**Act**	**Details for Non-Compliant Files**
Criteria	Percentage Compliant				**Percentage Compliant**	
	goal 90-95% (# compliant/# total applicable)					
patients confined at least 12 months? [90% compliance]						
4. A dilated eye exam is completed annually? [95% compliance]	*NA*	100% (6/6)	100% (4/4)	33% (1/3)	83% (10/12)	2 of 12 files non-compliant: Patients 7, 13: No evidence of dilated eye exam completed annually. Risk for non-compliance: Delay in care, where dilated eye exams were not consistently performed and completed.
5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet the standard for "good control"? [72% compliance]	100% (3/3)	100% (10/10)	100% (10/10)	82% (9/11)	100% (19/19)	Compliant.

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
1. Is there evidence that blood sugars are monitored in accordance with the treatment plan?	Observation: Forvis Mazars' review of one patient file showed inconsistent and untimely Chronic Care visits to address abnormal lab results and adjust treatment plans accordingly. Another patient file reviewed showed delayed Receiving Screening completion beyond the required 8-hours from applicable Book-In time, resulting in delayed orders for required Diabetes medications and blood sugar monitoring. A review of several patient files showed lab draw tasks inconsistently performed and untimely, with multiple unexplained rescheduled appointments, resulting in delayed Chronic Care visits and treatment plans. Additionally, Forvis Mazars' review of two patient files showed a risk for non-compliance related to a delay in care. A psychiatrist ordered a lab draw task, which revealed an elevated hemoglobin A1c. However, there was no documented evidence of chronic care follow-up by the medical provider regarding the abnormal lab results until the psychiatrist prompted a response one to two months later, resulting in a delay in care. Site policy requires the Receiving Screening is performed upon arrival at booking to ensure that emergent and urgent health needs are met (HCD-110_E-02). NCCHC standards require the Receiving Screening to take place as soon as possible upon acceptance into custody. The Consent Decree mandates that patients are processed through intake within 8-hours. Inability to provide timely and appropriate care in accordance with clinical practice standards and policy 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. Recommendation: • Continue Improvement Plan implementation to require appropriate and timely care delivery, include the review of case studies with Clinical Team as a part of continuous improvement. • Continue to perform ongoing auditing and monitoring. Report results of auditing and monitoring to the ACSO. • Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, AFBH, and specialty referrals to uniformly manage and share information across teams and systems.
2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract?	Observation: For one patient file reviewed, while lab draw tasks were ordered timely, lab draw tasks were not consistently performed and completed, with multiple unexplained rescheduled appointments. Inability to provide appropriate and timely care in accordance with clinical practice standards, 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. Recommendation: • Continue Improvement Plan implementation to require appropriate and timely care delivery, include the review of case studies with Clinical Team as a part of continuous improvement. • Reassess staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs. • Continue to perform ongoing auditing and monitoring. Report results of auditing and monitoring to the ACSO. • Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, and specialty referrals to uniformly manage and share information across teams and systems.
3. An examination of feet for neuropathy using a nylon filament is completed annually on patients confined at least 12 months?	Observation: Forvis Mazars' review of the selected patient files who have been confined at least 12 months or more showed no documented evidence of a nylon filament used as part of the examination of the patients' feet. However, Forvis Mazars did observe provider assessment documentation, evaluating the patients' feet for neuropathy and open wounds. Adequate evaluation and consistent documentation of early assessment symptoms of neuropathy helps prevent disease process complications, and patient injury and/or harm. Recommendation: • Re-evaluate need for examination of feet using nylon filament against evidence-based practice or HEDIS requirements; update applicable policy and procedure and standard of practice accordingly. • Continue to perform ongoing auditing and monitoring. Report results of auditing and monitoring to the ACSO.
4. A dilated eye exam is completed annually	Observation: Forvis Mazars observed that for two of the patient files reviewed, an annual dilated eye exam was not ordered, performed, and completed. Inability to provide timely and appropriate care in accordance with clinical practice standards and policy increases the risk

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
	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. Recommendation: • Continue Improvement Plan implementation to require appropriate and timely care delivery, in collaboration with Specialists. • Consider implementing eye clinic triage process to prioritize treatment visits as appropriate. • Hold Specialists accountable for inadequate care and/or delayed care. • Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, and Specialists 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. • Continue to perform ongoing auditing and monitoring of care delivery appropriateness, timeliness, care coordination. Report results of auditing and monitoring to the ACSO.
5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet the standard for "good control"?	Criteria met.

APPENDIX

PROJECT DETAILS

Project Scope	Assess and evidence ACSO compliance with requirements applicable to Alameda County's Santa Rita Jail (SRJ) adult correctional facility, specifically Continuous Quality Improvement (CQI) activities 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. CONTINUOUS QUALITY IMPROVEMENT STUDY REVIEW

As described in the Project Details section, to provide expanded Medical Quality Assurance (QA) services for the ACSO, Forvis Mazars performed CQI program review and support to evaluate ongoing CQI monitoring activities, performance improvement strategies, and change implementation effectiveness. Forvis Mazars provided focused CQI recommendations to help assure appropriate access, timeliness, and continuity of care delivery.

Forvis Mazars conducted medical record review of up to 30 incarcerated individual (patient) files against Wellpath's CQI criteria for the defined studies outlined in the 2024 CQI calendar and guidance. Forvis Mazars performed medical record review after Wellpath's scheduled initial audit and implementation of a related Improvement Plan. Wellpath's subsequent re-evaluation is pending completion. Forvis Mazars performed the review to examine change implementation effectiveness and long-term performance of the improvement strategy, consistent with the widely used Plan-Do-Study-Act (PDSA) model:

- Plan – Plan a change or test aimed at an identified problem:
  - Wellpath CQI study calendar by month, date range for data collection, and criteria questions specific to plan details.
- Do – Carry out the change or test:
  - Initial Wellpath CQI study audit and evaluation.
- Study – Analyze the results of the CQI study to learn opportunities of improvement:
  - Wellpath Improvement Plan development, implementation, and re-evaluation for initial overall compliance performance of less than 90-95% compliance threshold.
- Act – Run through the cycle again to determine adopt or abandon change:
  - Forvis Mazars CQI review to identify additional risks for non-compliance and need for corrective action plan (CAP).

The compliance threshold of 90% or 95% is determined by Wellpath's CQI study guidance. A compliance score less than a 90-95% threshold warrants a CAP. The CAP includes enhanced action steps consistent with the observations and recommendations provided, including re-evaluation within six months or more to demonstrate long-term change implementation effectiveness, as applicable.

<u>May 2024 CQI 1st Re-evaluation Study:</u>

- **Plan-Do** – Wellpath performed the following activities:
  - Audited 16 patient files during the 2/1 – 4/30/2024 date range, against the following criteria:
    1. Is there evidence that blood sugars are monitored in accordance with the treatment plan? [90% compliance]
    2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract? [95% compliance]
    3. An examination of feet for neuropathy using a nylon filament is completed annually on patients confined at least 12 months? [90% compliance]
    4. A dilated eye exam is completed annually? [95% compliance]
    5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet the standard for "good control"? [72% compliance]
  - Established compliance threshold of 90-95%.
  - Developed an Improvement Plan on 5/13/2024 based on 1st re-evaluation audit score of 72%.
- **Study** – Wellpath conducted the 2nd re-evaluation of Diabetes-HEDIS in July 2024.

<u>July 2024 CQI 2nd Re-evaluation Study:</u>

- **Plan-Do** – Wellpath performed the following activities:
  - Audited 13 patient files during the 6/13 – 7/30/2024 date range, against the following criteria:
    1. Is there evidence that blood sugars are monitored in accordance with the treatment plan? [90% compliance]
    2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract? [95% compliance]
    3. An examination of feet for neuropathy using a nylon filament is completed annually on patients confined at least 12 months? [90% compliance]

METHODOLOGY

4. A dilated eye exam is completed annually? [95% compliance]
5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet the standard for "good control"? [72% compliance]

- Established compliance threshold of 90-95%.
- Developed an Improvement Plan for one deficient criterion on 7/29/2024 based on 2nd re-evaluation audit score.

- **Study** – Based on the 2024 CQI calendar, Wellpath conducted the 2024 initial Diabetes - HEDIS study in November 2024.

November 2024 CQI Initial Study:

- **Plan-Do** – Wellpath performed the following activities:
  - Audited 14 patient files during the 10/1/2024 – 11/7/2024 date range, against the following criteria:
    1. Is there evidence that blood sugars are monitored in accordance with the treatment plan? [90% compliance]
    2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract? [95% compliance]
    3. An examination of feet for neuropathy using a nylon filament is completed annually on patients confined at least 12 months? [90% compliance]
    4. A dilated eye exam is completed annually? [95% compliance]
    5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet the standard for "good control"? [72% compliance]
  - Established compliance threshold of 90-95%.
  - Developed an Improvement Plan for one deficient criterion on 11/7/2024 based on initial audit score.
- **Study** – Wellpath conducted the re-evaluation of Diabetes-HEDIS in January 2025.

January 2025 CQI 1st Re-evaluation Study:

- **Plan-Do** – Wellpath performed the following activities:
  - Audited 13 patient files during the 12/1/2024 – 12/31/2024 date range, against the following criteria:
    1. Is there evidence that blood sugars are monitored in accordance with the treatment plan? [90% compliance]
    2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract? [95% compliance]
    3. An examination of feet for neuropathy using a nylon filament is completed annually on patients confined at least 12 months? [90% compliance]
    4. A dilated eye exam is completed annually? [95% compliance]
    5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet the standard for "good control"? [72% compliance]
  - Established compliance threshold of 90-95%.
  - Developed an Improvement Plan on 11/7/2024 based on 1st re-evaluation audit score.
- **Study** – Wellpath re-evaluated 13 patient files during the 12/1– 12/31/2024 date range, against all the criteria listed above. As the re-evaluation did not meet compliance threshold, a second Improvement Plan was created on January 20, 2025, with another planned re-evaluation 3/6/2025.
- **Act** – Forvis Mazars performed the following activities:
  - Evaluated 24 patient files against the Diabetes-HEDIS criteria during the 11/1/2024 – 1/31/2025 audit timeframe, to evaluate continued compliance.
  - Provided focused CQI observations and recommendations for a CAP, including enhanced action steps and re-evaluation.

B. CONTINUOUS QUALITY IMPROVEMENT PROGRAM GUIDANCE

A continuous quality improvement (CQI) program monitors and improves health care delivered in the facility (NCCHC essential standard J-A-06)

- Compliance Indicators:
  1. The responsible health authority establishes a CQI program that includes a quality improvement committee consisting of health staff from various disciplines. Additional participants may be included, depending on the issues being addressed.
  2. CQI meeting minutes or summaries are made and retained for reference, and copies are available and reviewed by all appropriate personnel. CQI meeting minutes should provide sufficient detail to guide future decisions.
  3. Health record reviews are done under the guidance of the responsible physician or designee to ensure appropriate care is ordered and implemented and that care is coordinated by all health staff, including medical, dental, mental health, and nursing.
  4. Beyond chart reviews, the responsible physician is involved in the CQI process.
  5. When the CQI committee identifies a site-specific health care concern from its monitoring, a process and/or outcome quality improvement study is initiated and documented.
     a. Process quality improvement studies examine the effectiveness of the health care delivery process.
     b. Outcome quality improvement studies examine whether the expected outcomes of patient care were achieved.
  6. At least one process and/or outcome quality improvement study is completed per year.
  7. The CQI committee documents a written annual review of the effectiveness of the CQI program by reviewing CQI studies and minutes of CQI, administrative, and/or staff meetings, or other pertinent written materials.
  8. All aspects of the standard are addressed by written policy and defined procedures.
- One essential element of quality improvement is the monitoring of high-risk, high-volume, or problem-prone aspects of health care provided to patients.
- Recommended areas to study can be consistent with regularly monitored statistical reports (NCCHC essential standard A-04):
  - Service volume.
  - Referral to specialists.
  - Deaths.
  - Incidence of certain illnesses.
  - Infectious disease monitoring.
  - Emergency services and hospital admissions provided.
  - Access, timeliness of health services, and follow-up.
  - Missed appointments.
  - Grievance statistics.
- Success of compliance with CQI program standards is measured by the relevance of the studies and effectiveness of the improvement strategies and corrective action.
- The CQI program should use one or more of these quality performance measures when designing studies:
  - Accessibility.
  - Appropriateness of clinical decision making.
  - Continuity.
  - Timeliness.
  - Effectiveness.
  - Efficiency.
  - Prescriber-patient interaction.
  - Safety.
- The CQI program should measure one or more of the following major service areas annually:
  - Intake processing.
  - Acute care.
  - Medication services.
  - Chronic care services.
  - Intra-system transfer services.
  - Scheduled off-site services.
  - Unscheduled on-site and off-site services.
  - Mental health services.
  - Dental services.
  - Ancillary services.
  - Dietary services.
  - Infirmary services.

As part of a continuous quality improvement (CQI) Program, patients with chronic disease, other significant health conditions, and disabilities receive ongoing multidisciplinary care aligned with evidence-based standards (NCCHC essential standard J-F-01).

- Compliance Indicators:
  1. Patients with chronic diseases and other special needs are identified.
  2. The responsible physician establishes and annually approves clinical protocols.

3. Clinical protocols are consistent with national clinical practice guidelines.
4. Clinical protocols for the identification and management of chronic diseases or other special needs include, but are not limited to, the following:
    a. Asthma.
    b. Diabetes.
    c. HIV.
    d. Hyperlipidemia.
    e. Hypertension.
    f. Mood disorders.
    g. Psychotic disorders.
5. Individualized treatment plans are developed by a physician or other qualified provider at the time the condition is identified and updated when warranted.
6. Documentation in the health record confirms that providers are following chronic disease protocols and special needs treatment plans as clinically indicated by:
    a. Determining the frequency of follow-up for medical and mental health evaluation based on disease control.
    b. Monitoring the patient's condition (e.g., poor, fair, good) and status (e.g., stable, improving, deteriorating) and taking appropriate action to improve patient outcome.
    c. Indicating the type and frequency of diagnostic testing and therapeutic regimens (e.g., diet, exercise, medication).
    d. Documenting patient education (e.g., diet, exercise, medication).
    e. Clinically justifying any deviation from the protocol.
7. Chronic illnesses and other special needs requiring a treatment plan are listed on the master problem list.
8. Medical and dental orthoses, prostheses, and other aids to reduce effects of impairment are supplied in a timely manner when patient health would otherwise be adversely affected, as determined by the responsible physician or dentist.
9. All aspects of the standard are addressed by written policy and defined procedures.

C. APPLICABLE POLICY AND PROCEDURE

Wellpath Policy and Procedure HCD-110_F-01 Patients with Chronic Disease and Other Special Needs-Alameda CA, requires routinely scheduled encounters at least every 90 days between a mid-level provider or MD and a patient with an identified chronic medical or mental condition for treatment planning, monitoring the patient's condition and therapeutic regimen while in custody. Routinely scheduled Chronic Care Clinic monitoring shall apply to the following conditions:

- Diabetes, Cardiac Disorders, Hypertension, Seizure Disorders, Communicable Diseases, Respiratory Disorders, and Psychiatric disorders.
- Other conditions may be included as appropriate at the discretion of the medical provider.
- Patients designated Mental Health Special Needs may include, but are not limited to, those who are diagnosed with severe mental illness (including Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, moderate to severe Major Depression, mood disorders, and Post Traumatic Stress Disorder), diagnosed with Developmental Disability, Gender Dysphoria, juveniles in adult custody, and those who are prescribed antipsychotic medications to treat psychosis.
- Patients designated as special needs may include, but are not limited to, frail or elderly, terminally ill whose life expectancy is less than a year, the chronically ill, those with special mental/mental health needs, developmentally disabled individuals, patients diagnosed with Gender Dysphoria, pregnant patients, dialysis, physically handicapped patients (e.g., amputations, para or quadriplegia, wheelchair bound, etc.), and individuals diagnosed with a communicable disease.