EXHIBIT 2

Duvall Settlement Agreement
Semi-Annual Compliance Report
Maryland Division of Pre-Trial and Detention Services

Reporting Period: July 1, 2019 through December 31, 2019

Table of Contents

Executive Summary

This executive summary represents the Corizon Health efforts in demonstrating compliance with the Duvall Settlement Agreement for the period of July 1 through December 31, 2019 at BCBIC. This semi-annual report serves as documentation the efforts made by the Corizon Health team to provide medical services consistent with the medical provisions outlined within the agreement. The medical provisions of the settlement agreement include:

SA 17: Intake and Initiation of Medication
SA 18: Medical Plan of Care
SA 19: Medication Management and Testing
SA 20: Interaction between Medical and Custody
SA 21: Accommodations for Plaintiffs with Disabilities
SA 22: Specialty Care/Consultation
SA 23: Sick Call, and,
SA 24: Medical Records

Duvall Strategic Compliance Team Design

The Strategic Compliance Team is tasked with the clinical monitoring, data analysis, interpretation and reporting of compliance with the settlement agreement. This team, comprised of analysts and registered nurses, possess a varied skillset with includes certifications in Lean Healthcare and Lean Six Sigma, certification in correctional healthcare, public health nursing, critical incident response, performance improvement, program development and evaluation, and medical billing and coding. Former team experience ranges from clinical educators, military veterans, former custody leadership, site ancillary support staff, former site, regional and corporate leadership, and front-line healthcare staff.

Continuous Quality Improvement

Duvall compliance efforts are designed with a focus on the assessment of processes and outcomes, with candid evaluation of the current state and providing support to the site leadership team in the development of performance improvement plans and actions to move to the desired state of compliance. Audit indicators and compliance thresholds were developed in collaboration with the DPSCS Continuous Quality Improvement Manager and the Corizon Health Quality Improvement and Patient Safety teams to identify process and outcome indicators to evaluate care delivery and patient care outcomes. Audit indicators and outcome measures were developed consistent with established DPSCS Clinical Protocols, with added focus on the essential elements of compliance outlined within the settlement agreement, which parallel contractual obligations. Efforts are ongoing to establish a methodology with operational definitions (noted in Appendix A) that can allow results (noted in Appendix B) to be duplicated, with findings reported with the vigor and integrity that prove them accurate and reliable.

Challenges, Barriers and Opportunities

The largest barrier in achieving compliance has been the technology limitations with existing jail management (OCMS) and EPHR systems. Frequent system glitches, equipment malfunction, slow turnaround time in resolving repairs on the custody and healthcare provider fronts are factors that contribute to poor compliance. The data feed from the OCMS to the EPHR has proven unreliable, with booking data being lost, deleted or formulated with errors. Challenges with the systems that process and book detainees into the system are with significant faults that impact the timely migration of health data captured in the OCMS to the EPHR. Upgrades and improvement to the IT infrastructure and EPHR are forthcoming, with hopes this can support compliance efforts.

Duvall Settlement Agreement Provision 17: Intake and Initiation of Medication

SA 17A: Fit for Confinement (Accept)
Audit Methodology

The eligible audit population included all detainees booked into the BCBIC during the audit period.

For this reporting period, the sample size for monthly auditing of this provision was set at a threshold of 65. The rationale for the selection of this sample size is based on the premise that audits are completed on a monthly basis, and reported over a six month time period to demonstrate a 95% confidence level, with a 5% confidence interval. As such, when the total eligible population is calculated using a sample size calculator (similar to one located on website www.surveysystem.com/sscalc.htm), it yields a minimum sample size of 371. When this is divided over a 6-month reporting period, a minimum number of 62 records were required for auditing each month. For ease of auditing, a sample size of 65 records were audited.
For the reporting period of July to December of CY 2019, audit sampling yielded the following:

	Jul	Aug	Sep	Oct	Nov	Dec	*Grand Total*
Booking Totals	2103	1996	1843	1958	1637	1478	*11,015*
Sample Size	65	65	65	65	65	65	*390*

Audit Indicators

Audit indicators for this section of the provision measured the processes and outcomes relating to the completion and migration of the IMMS within 4 hours, of which must be completed by an RN or higher:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
IMMS is completed within 2 hours of scan-in time	89%	100%	95%	95%	97%	98%	***97%***
IMMS migrated to the EPHR within 4 hours of scan-in time	72%	83%	71%	80%	72%	69%	***75%***
IMMS completed by an RN or higher	100%	100%	100%	100%	100%	100%	***100%***
Score Summary for SA 17A (Accept)	***87%***	***94%***	***89%***	***92%***	***90%***	***89%***	***90%***

SA 17A: Not Fit for Confinement (Reject)
Audit Methodology

The eligible audit population included 100% of those detainees rejected for admission/booking into the facility during the audit period. However, the sample population included those detainees that were rejected ***and*** returned to the facility after being previously rejected. For the reporting period of July to December of CY 2019, audit sampling yielded the following:

	Jul	Aug	Sep	Oct	Nov	Dec	*Total*
Total Rejections	31	34	32	25	22	18	*162*

Audit Indicators

Audit indicators for this section of the provision measured the processes and outcomes relating to the completion and migration of the IMMS within 4 hours upon return to the facility, of which must be completed by an RN or higher. In addition, detainees that return to the facility after rejection must be evaluated by the provider:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
IMMS migrated to EPHR within 4 hrs of scan-in time upon return to the facility for rejects	39%	80%	87%	69%	73%	60%	***68%***
IMMS is completed by an RN or higher	96%	100%	100%	100%	100%	100%	***99%***
Provider encounter note in EPHR following ER return	83%	64%	88%	80%	95%	100%	***85%***
Score Summary for SA 17A (Reject):	***73%***	***81%***	***92%***	***83%***	***89%***	***87%***	***84%***

Opportunities for Improvement

Measurement of the IMMS process is with its limitations that appear to be largely related to technology challenges that limit the accurate capture of data. System migration glitches and equipment malfunctions within scanners, computers, fingerprinting and DNA databases to the delays in migration of data from one system (OCMS) to the other (EPHR). While significantly improved since the previous reporting period, the inability to accurately reconcile system reporting outputs and manual logs further contribute to the inability to obtain documented compliance with this provision. While review of manual arrival logs may prove primitive, it may prove valuable to revisit them and identify a robust reconciliation process between the system and the manual logs to demonstrate compliance until the appropriate system upgrades can be implemented.

SA 17B: Urgent Medical Needs

Audit Methodology

The eligible audit population were patients who reported during the IMMS use of medications and/or an urgent medical condition. The eligible audit population were, of the detainees identified in provision SA 17A, those that answered "yes" to any question under the medical or mental health section on the IMMS form, or, anyone marked urgent or emergent in the IMMS disposition section of the IMMS form for medical ***or*** mental health, or, anyone with comments in this section that would indicate the need for an urgent medical or mental health referral:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There is documentation on the IMMS of an urgent medical and/or mental health referral	92%	85%	91%	95%	93%	89%	***91%***
There is documentation of same arrestee's name as an urgent referral on the IMMS Referral Log, same date as IMMS	100%	100%	100%	100%	100%	95%	***91%***
Medical Provider encounter for urgent referral completed within 24 hours of intake screening, or sooner if clinically indicated	90%	92%	91%	98%	96%	96%	***94%***
Score Summary for SA 17B:	***94%***	***92%***	***94%***	***98%***	***96%***	***93%***	***95%***

SA 17C: Urgent Mental Health Needs

Audit Methodology

The eligible audit population for this provision were patients who reported use of medications during the IMMS and/or an urgent mental health condition. The eligible audit population were, of the detainees identified in provision SA 17B, those that answered "yes" to any question under the mental health section on the IMMS form (i.e., there is evidence of documentation of mental health related issues prior hospitalization for mental health issues, psychotropic meds, history of suicide, etc.), anyone marked urgent or emergent in the mental health disposition section of the IMMS form ***in OCMS,*** or anyone with comments in this section that would indicate the need for an urgent or emergent mental health referral:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There is documentation on the IMMS of an urgent or emergent referral to mental health	97%	78%	66%	79%	70%	58%	***75%***
There is documentation of same arrestees name on the urgent mental health referral log, same date as the IMMS	64%	64%	52%	36%	41%	23%	***47%***
There is a medical provider encounter for the urgent or emergent mental health need completed within 24 hours of the intake screening or sooner, if clinically indicated	81%	81%	79%	96%	98%	100 %	***89%***
There is documentation in EPHR from the medical provider referring the individual to the mental health provider.	87%	68%	78%	90%	83%	96%	***84%***
There is documentation of a mental health provider encounter for urgent mental health referral completed within 24 hours of medical provider referral, or sooner if clinically indicated	96%	93%	67%	57%	40%	38%	***65%***
Score Summary for SA 17C:	***85%***	*77%*	***68%***	*71%*	***66%***	*63%*	***72%***

Opportunities for Improvement

In a multi-vendor model of care delivery, the completion of the intake screening process requires an accurate system of identification of somatic and behavioral health needs, with a seamless system of referral to the behavioral health team for evaluation. Clarity in the performance expectation of nurses and providers in the process are imperative; both have to be aware of who is responsible for generating the referral to the mental health provider, and who is responsible for placing the patient on the log. In addition, improved communication between the two vendors and a review of the reconciliation process of patients with identified mental health needs are required to ensure that patient needs are identified, and potential sources of system failures are addressed. Current efforts in streamlining the IMMS process are in progress, with multi-vendor meetings occurring on a weekly and monthly basis to discuss potential process improvements with front line supervisory staff and regional leadership team members.

SA 17D and SA 17E: Initiation and Continuation of Medications

Audit Methodology

The eligible audit population for this provision were patients who reported during the IMMS screening process use of medical or behavioral health medications during the audit period. The eligible sample population were all patients identified in 17B that answered "yes" to currently taking medication prescribed by a physician in the medical and/or mental health section on the IMMS:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There is medication order documented for any chronic care or acute medications identified/reported at IMMS or alternative medications ordered	88%	100%	96%	95%	97%	100%	***96%***
There is a MAR generated documenting chronic or acute medications identified during the intake receiving process (IMMS) or alternative medications ordered	77%	32%	52%	51%	79%	77%	***61%***
First dose medications reported as IMMS or alternative medication ordered were administered within 24hs of the IMMS in OCMS	59%	32%	35%	21%	59%	52%	***43%***
There is explanation in EPHR for non-ordered medications listed as current by the arrestee	87%	100%	100%	100%	100%	86%	***95%***
Score Summary for SA 17D & SA 17E:	***78%***	***66%***	***71%***	*67%*	***84%***	*79%*	***74%***

Opportunities for Improvement

The intake screening process and the medical determination of a patient's suitability for confinement presents as the most vulnerable period of the detainee's stay in the facility. Despite the dynamic nature of the intake receiving area, nurses assigned to the intake area must be detail-oriented, ensuring that all data fields are addressed, objective and subjective data received is documented and the appropriate referrals are made consistently via established processes. Continuation of medications must be followed through from the time the medication is ordered to administration; failure to document same on the hard copy medication administration record will continuously prove a barrier to document that care has been provided as ordered and available for the healthcare team to formulate a plan of care.

Qualitative Review of Nurse Intake Screenings

Audit Methodology

The approach used to determine the quality of the nursing IMMS was that of a peer review. Each month, a different RN assigned to the sallyport during the calendar month was identified, and a sample of up to 10 patient of whom they completed an IMMS were reviewed. For nurses that rotate through the sallyport infrequently, charts were obtained from various dates throughout the audit month to obtain a total of 10 charts, whenever possible. Efforts were made to ensure that nurses reviewed during the 6-month reporting period where not re-audited, whenever possible.

Detainees were identified based on the need for an urgent referral to the provider or previous rejection from the facility. These patients were selected from the IMMS Migration Report sorted by staff name, as well as a review of the SSRL for those patients with an urgent referral documented. Scoring was based on the total number of correct attempts as the numerator and the total possible opportunities for each indicator as the denominator. A percentage score was assigned for ease in evaluation, which advised of the percentage that the specific indicator is performed correctly. This provides specific guidance on which component of the IMMS screening requires focused intervention:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Intake Screening form is completed in its entirety with no blanks	78%	95%	90%	73%	70%	83%	***82%***
Vital signs and peak flow (respiratory problems) and/or random finger stick glucose (diabetics) were documented	59%	87%	58%	63%	73%	83%	***71%***
Point of Care Testing is documented on the IMMS in the comments section	59%	51%	50%	42%	70%	61%	***56%***
Baseline CIWA or COWS scores are documented on the IMMS for all individuals who reports drug or alcohol use	76%	75%	32%	71%	39%	45%	***56%***
The individual was triaged and referred appropriated based on the nursing assessment and IMMS responses	70%	67%	95%	88%	70%	61%	***75%***
Score Summary for SA 17 Qualitative:	***68%***	***75%***	***65%***	***67%***	***64%***	***66%***	***68%***

Opportunities for Improvement

Improvement in the qualitative aspects of the nursing IMMS will require a thorough review of current IMMS processes and workflows. Opportunities for consistency in intake personnel assignments and documentation within the OCMS (including completion of all data fields), completion of required POCT and screenings can be achieved with adequate oversight and performance management of nurses conducting IMMS screenings. Strong educational initiatives are essential in validating the skill sets of nurses that complete IMMS screenings to include conducting focused clinical assessments, identification of urgent and emergent medical conditions, phlebotomy skills, documentation, problem solving, critical thinking, and motivational interviewing.

Duvall Settlement Agreement Provision 18: Medical Plan of Care

Audit Methodology

The eligible audit population for this provision were identified patients that were identified as medically complex. In the absence of a single quantitative measure or recognized method of determining "medical complexity," patients were identified from the top 50 hospital discharge diagnoses for BCBIC for the month audited. Discharge diagnoses excluded were those relating to mental health, injuries/trauma, and orthopedic/surgical problems. These discharge diagnoses were cross-referenced with the AHRQ PQI's which yields the audit sample for the reporting month. When an adequate sample isn't obtained using the above method, the sample is supplemented with patients with hospital discharge diagnoses of sepsis, substance abuse withdrawal, sickle cell disease, arrhythmias and heart failure.

When the audit sample has been identified, the health record is reviewed to cover a time span adequate to evaluate the problem being reviewed. Ideally, this should consist of multiple provider visits over a period of time and should not focus solely on a single episode of care. Encounters included within the review should include nurse and provider sick call, onsite and off-site specialty care, sallyport assessments, IMMS screenings and 7-Day History & Physical, and chronic care appointments. For each episode of care, all the elements of the medical plan of care must be documented to include testing, referrals, and necessary timeframe for follow-up:

For each audit indicator, the appropriate code is assigned that is associated with the clinical episode utilizing the operational definition listed with the identified code. The code is only applied when the encounter fails to have met the operational definition of the indicator (i.e. "N"). The most recurrent code used across all charts audited are then identified. For that code, the root cause is identified for that code being assigned and a determination is made if it was an operational (i.e. protocol, policy) or practice (i.e. training) gap. As the final step, actions to be implemented to remedy the gap to obtain a desired state of compliance are identified:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Do the CC Encounters address the specific problems identified at the 7 day Intake Exam (excluding those issue that are resolved/inactive)?	100%	60%	100%	86%	100%	100%	***91%***
Are needs for disease-specific lab test monitoring evaluated, reviewed, or ordered?	100%	57%	71%	100%	83%	80%	***82%***
Is compliance with chronic medications and or diets assessed as part of the Plan of Care?	100%	0%	80%	83%	60%	75%	***66%***
Is there indication that the chart summary and the hard copy medical record was reviewed?	71%	57%	88%	100%	78%	100%	***82%***
Have episodic recurrent non serious medical problems been assessed with a plan of care?	67%	100%	100%	100%	100%	100%	***95%***
Do Intake Screening encounters reflect appropriate CC registration status (with updating or enrollment where applicable) and scheduling for CC encounter(s)?	78%	100%	89%	60%	100%	88%	***86%***
Are newly identified CC conditions updated to the Problems List?	57%	100%	50%	71%	75%	80%	***72%***
Is the disease activity and control clearly indicated in the Plan of Care?	100%	100%	100%	100%	100%	100%	***100%***
Is review of external specialty care and hospital or Infirmary summary /reports and recommendations clearly documented?	40%	50%	67%	67%	71%	60%	***59%***
Score Summary for SA 18:	***79%***	***69%***	***83%***	***85%***	***85%***	***87%***	***81%***

Process and Operational Gaps Identified	
Do the CC Encounters address the specific problems identified at the 7 day Intake Exam (excluding those issue that are resolved/inactive)?	• Clinical Information is insufficient to document disease activity • Delay/lapse in a necessary clinical support service or function (e.g., x-ray, SAW monitoring, ambulance/transport) • Provider assessment does not augment, compliment or affirm prior assessments, priorities and interventions
. Are needs for disease-specific lab test monitoring evaluated, reviewed, or ordered.	• Information is insufficient to ensure continuity with care in the community (i.e., the ongoing/last known sources of care in the community reasonable sought/identified) • Clinical Information is insufficient to document disease activity (i.e., the physical examination is not appropriate for the age, conditions, and health risks of the detainee)
Is compliance with chronic medications and or diets assessed as part of the Plan of Care?	• Information is insufficient to ensure continuity with care in the community (i.e., the ongoing/last known sources of care in the community reasonable sought/identified) • Consultation request/specialty appointment not scheduled/completed with the urgency in which it was assigned
Is there indication that the chart summary and the hard copy medical record was reviewed?	• Information is insufficient to ensure continuity with care in the community (i.e., the ongoing/last known sources of care in the community reasonable sought/identified) • Disposition is incomplete or not prioritized
Have episodic recurrent non-serious medical problems been assessed with a plan of care?	Disposition is incomplete or not prioritized
Do Intake Screening encounters reflect appropriate CC registration status (with updating or enrollment where applicable) and scheduling for CC encounter(s)?	• Provider assessment does not augment, compliment or affirm prior assessments, priorities and interventions • Disposition is incomplete or not prioritized
Are newly identified CC conditions updated to the Problems List?	• Provider assessment does not augment, compliment or affirm prior assessments, priorities and interventions • Disposition is incomplete or not prioritized • Delay in follow-up of consultation or other health visit
Is the disease activity and control clearly indicated in the Plan of Care?	No gaps identified during the reporting period.
Is review of external specialty care and hospital or Infirmary summary /reports and recommendations clearly documented?	• Consultation request/specialty appointment not scheduled/completed with the urgency in which it was assigned • Delay in escalation of care or referral to appropriate provider (i.e., includes specialty providers and vendor partners)

Opportunities for Improvement

Consistent themes noted in health records reviewed note that there were inconsistencies in the documentation of disease activity and control. This, along with other noted inconsistencies in documentation practice do not maximize the benefit of an electronic health record. Thus "meaningful use" is not facilitated. The EPHR requires updating to facilitate high quality documentation. Capabilities for data management and sampling methodologies are constrained by the current data systems that are not able to normalize data on care services by length of stay or other parameters critical for evaluating data within such a broad scope of this provision.

Duvall Settlement Agreement Provision 19: Medication Management and Testing

SA 19A: Chronic Care Medication Renewal

Audit Methodology

The eligible audit population for this provision were patients who were listed on the chronic care registry cross-referenced with a 30-day medication expiration report, to determine if patients receiving medications for long-term use are continued without interruption through adequate management within the designated chronic care clinic for their condition:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Compliance with chronic care policy as shown by order in EPHR for this patient to be seen in Chronic Care Clinic for his/her previously diagnosed chronic health condition	82%	74%	92%	55%	92%	97%	***82%***
Compliance with chronic care policy for the first appointment within 30 days or as clinically ordered as shown by EPHR review calculated as time between order date and chronic care appointment	77%	57%	71%	41%	62%	74%	***64%***
Ongoing compliance with chronic care clinics within 90 days or as clinically ordered shown by EPHR review calculated as time between the last chronic care encounters	67%	38%	60%	16%	33%	55%	***45%***
Chronic medications ordered for 120 days as shown by the start and stop dates on the order in EPHR	66%	42%	66%	34%	60%	65%	***56%***
Start and stop dates accurately transcribed on MARs	43%	40%	44%	25%	49%	62%	***44%***
A review of the MAR shows continuity of medications without interruption	41%	32%	90%	60%	74%	82%	***63%***
Score Summary for SA 19A:	***63%***	***47%***	***71%***	***39%***	***62%***	***72%***	***60%***

Opportunities for Improvement

Improvement is needed to establish a consistent process for patients to be identified and seen for the initial chronic care appointment. At present, the patient is seen on average 4 separate occasions by a provider within the first 14 days if identified with an urgent healthcare need at the time of intake. An opportunity to condense these visits to serve as the initial chronic care appointment would be ideal, and reduce the excess provider encounters and increase provider availability to provide care that requires a higher level clinician. Also, providers are inconsistent with the duration of chronic care medications at the sallyport, 7-Day Intake and 30 day initial Chronic Care appointments; some providers are ordering medications for 90 days, 30 days and/or 60 days. It is expected that if there is consistent performance of medication ordering across providers, medication renewals will occur with minimal lapses.

SA 19B: Medication Administration

Audit Methodology

The sample population for this provision were patients who were identified in SA 19B:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Medication administered by LPN or higher (confirmed by signature and licensure documented on the back of the MAR – LPN, RN, PA, NP)	11%	12%	46%	20%	38%	46%	***29%***
Medications administered as ordered (no holes/blanks) – "N" for any hole or blank	83%	35%	92%	55%	57%	85%	***68%***
Missed medication documented using approved codes	71%	52%	61%	30%	51%	63%	***55%***
Number of blanks or holes in the MAR (number of missed doses with no explanation)	127	173	6	38	103	26	***79***
Legible name of nurses administering medications whose initials appeared on the MAR with applicable professional licensure documented at the back of each MAR	90%	80%	95%	65%	91%	95%	***86%***
Score Summary for SA 19B:	***64%***	***45%***	***74%***	***43%***	***59%***	***72%***	***57%***

Opportunities for Improvement

MAR documentation has proven challenging throughout the reporting period, with two of the greatest sources of adherence being the location of the MARs for auditing and the documentation of doses administered or omitted. Increased accountability of healthcare staff to address all medications to be administered during medication pass is essential in ensuring compliance with this provision, with regular and consistent monitoring by leadership and/or supervisory nurses in a timely manner at the end of the shift of administration, whenever possible. The availability of MARs for auditing this provision will require collaboration with the compliance auditors and site medical records staff to ensure MARs are available for review on a monthly basis.

SA 19C: Vital Sign and Blood Sugar Monitoring and Documentation

Audit Methodology

The eligible audit population were those patients that had clinician orders for vital signs and blood sugar testing during the audit period as noted through EPHR using the EPHR crystal reporting feature. All patients identified on these reports were included in the audit sample:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Vital signs completed and documented as ordered in EPHR	8%	4%	18%	7%	8%	0%	***8%***
Blood sugar tests completed and documented in EPHR as ordered	100%	13%	0%	0%	0%	29%	***24%***
Vital signs results documented as reviewed by clinician during patient encounter	6%	8%	10%	20%	5%	11%	***10%***
Blood sugar tests documented as reviewed by clinician during patient encounter	n/a	86%	75%	n/a	17%	86%	***66%***
Score Summary for SA 19C:	***38%***	***27%***	***26%***	***9%***	***7%***	***31%***	***23%***

Opportunities for Improvement

Ordering of vital signs and fingerstick glucose readings continues to be inconsistent during the reporting period. While improvements have been made with using the ordering template in EPHR, incorrect use of the template results in inaccurate Crystal reporting outputs, which at times, is not readily apparent to the clinical auditors. Collaboration with site operations and clinical leadership to maximize EPHR functionality through ordering vital signs and blood glucose testing though EPHR tasking features will create a system of accountability for ordering and accountability for execution.

Documentation of vital signs and fingerstick glucose readings remains inconsistent: inconsistent in location and inconsistent in completion as ordered by the provider. While significantly improved, there continues to be vital signs and blood sugar tests documented in the EPHR and on what is referenced by the site as Treatment Administration Records (TARs). TARs are not consistent with established DPSCS Clinical Services policies for documentation of clinical testing and use of the MARs. It proves challenging when auditing to ascertain if an omission on the TAR indicates that care was not provided, or, the care was provided and documented in the EPHR. It is recommended that performance expectations be established that all care provided to patients is documented in the applicable section of the EPHR for provider review and inclusion in the medical plan of care.

SA 19D: Keep-on-Person Medications

Audit Methodology

The eligible audit population for this provision included a sample of patients that were ordered medication as a keep-on-person and submitted a sick call slip for a medication refill and appeared on the 30 day medication expiration report who are prescribed inhalers, nitroglycerin and glucose tablets and/or any medication prescribed as KOP (i.e., creams, ointments, drops, vaginal/rectal suppositories):

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
KOP medication receipt by patient documented on MAR for each KOP refill request for the most recent sick call request for review	40%	42%	14%	9%	0%	17%	***20%***
No lapse in medication between dates refills were received by patient measured as the number of doses from last fill to the current fill	45%	38%	50%	14%	61%	86%	***49%***
Score Summary for SA 19D:	***43%***	***40%***	***32%***	***12%***	***31%***	***51%***	***35%***

Stock Medication Verification Process:

The Stock Medication Verification Process includes confirmation that those medications listed on the Dispensary Interim Emergency Medication Listing are available. This requires an inventory of these medications to confirm that these medications are present at the time of review. Of note, PAR levels were not measured during for this provision. The total number of medications to be provided will be the denominator, and the total number of medications confirmed during the inventory is the numerator, with a percentage being calculated to determine the percentage of medications available in the medication supply room:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Stock medication supply (presence of medication)	No data	No data	95%	90%	94%	96%	***94%***

Opportunities for Improvement

Limitations in the methods of clear identification of patients that are ordered a KOP medication with issuance of the medication as KOP is essential in establishing a consistent methodology of auditing. If changes are made to the ordering of a medication to DOT after the initial KOP order is written, documentation must be made in the medication order and/or EPHR to notate the change. Also, nursing staff must be empowered to follow-up with the ordering physician if there are observed concerns with medications ordered as KOP to allow the provider to change the order from KOP to DOT with the appropriate change noted in the EPHR.

Consistent use of the designated KOP stamp on MARs will increase compliance with this indicator. The use of handwritten notes on the MAR to document issuance of KOP medication should be limited, with compliance being measured by the presence of the patient's signature indicating that the medication has been received.

Stock medication supply inventories must be conducted regularly by site leadership or designee to ensure that rescue medications, such as inhalers and epinephrine, are available in sufficient quantities and are not expired.

SA 19E & SA 19F: Laboratory Testing (includes cultures for potential MRSA)

Audit Methodology

The eligible audit population for this provision were those patients listed on the EPHR Laboratory Tests Ordered report of abnormal and critical laboratory values for the month audited. During the reporting period, critical results were any test result that may require rapid clinical attention to avert significant patient morbidity or mortality, which includes cultures for MRSA. Seriously abnormal results were any test result that is not a critical value but requires timely intervention:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Lab requests are listed on the facility Lab Log? (Date of order, Date test drawn/completed, Date results received, Date results reviewed by provider, Date results shared with patients, and Date review was documented in health record)?	0%	0%	0%	0%	0%	0%	***0%***
There is evidence that the lab test was completed within the timeframe specified in the provider's orders?	13%	67%	91%	77%	46%	48%	***57%***
Stat labs results were received within (4) hours of the draw by a nurse or higher? (exception for tests that cannot be completed within timeframe, e.g. cultures)	n/a	n/a	n/a	n/a	n/a	0%	***0%***
If critical / abnormal results were noted, the provider was notified of the lab results? (Critical= Immediately (within 15 minutes of receipt), Abnormal= within same day received or within (4) hours)	7%	50%	30%	67%	27%	60%	***40%***
There is evidence that the lab result was Reviewed, Signed, and Dated by provider within 48 hours after receipt of test results?	13%	75%	60%	55%	46%	42%	***49%***
There is evidence that reviewed labs have written provider follow-up on lab values or test results? (within 24 hours of receipt for critical and abnormal results, 48 hours of receipt for normal results)	10%	100%	60%	33%	38%	32%	***46%***
There is documentation the patient was notified of normal /abnormal lab results? (Routine= 7 business days, Abnormal= 24 hours of receipt of results).	9%	50%	22%	25%	0%	21%	***21%***
The hard copy lab test result was uploaded into EPHR within 48 hours of the provider's date and signature?	0%	0%	0%	0%	46%	53%	***17%***
Score Summary for SA 19E and SA 19F:	***10%***	***68%***	***53%***	***51%***	***40%***	***41%***	***44%***

Opportunities for Improvement

Limitations with the laboratory vendor bi-directional interface with the EPHR to receive test results has been the greatest barrier in assessing compliance with this indicator. Current collaboration with ITCD and the laboratory vendor to institute a bi-directional data feed of provider test orders and test results are in progress, with resolution currently in progress. Until this bi-directional feed is fully functional and without error, an established means of receipt and review of laboratory tests has to be established, with increased provider accountability to review tests ordered, and revision of the plan of care when indicated.

SA 19G: Vital Sign and Blood Sugar Monitoring

Audit Methodology

The eligible audit population for this provision were those patients listed on the AIC >9 report for the audit period, and patients prescribed insulin and anti-hypertensive medications with monitoring parameters listed in the sig prescribing instructions:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There is an order for blood sugar or vital signs monitoring in EPHR by the provider with parameters in the audit period	26%	17%	34%	10%	6%	12%	***18%***
There is documentation in the EPHR that the vital signs and /or blood sugars were taken according to the provider orders during the audit period	12%	13%	2%	2%	3%	2%	***7%***
Abnormal results for vital signs and /or blood sugar have documentation in EPHR with nursing referral to the clinician during the audit period	24%	22%	35%	83%	0%	13%	***30%***
There is documentation of the review and disposition by the clinician in EPHR for abnormal readings of vital signs or accucheck as a result of that nursing referral during the audit period	13%	14%	24%	50%	0%	0%	***17%***
Blood sugar tests reported in the lab contractor blood sugar report documented as reviewed in EPHR by clinician during patient encounter during the audit period	23%	21%	76%	50%	100%	40%	***52%***
There is abnormal A1C >9 result for the audit period during the audit period	45%	7%	60%	100%	0%	100%	***52%***
Score Summary for SA 19G:	***24%***	***15%***	***39%***	***49%***	***18%***	***28%***	***29%***

Opportunities for Improvement

As with orders for vital signs and fingerstick glucose readings, the ordering of blood sugar testing within the EPHR is inconsistent. However, use of the ordering template has improved significantly from the previous reporting period. Collaboration with site operations, clinical leadership and the laboratory vendor to transition to ordering laboratory testing though the laboratory vendor interface and vital sign/fingerstick glucose tests thought the appropriate templates in the EPHR will create a system of accountability for provider ordering and accountability for nursing execution.

Of significant importance is the implementation of parameters of what is to be identified as abnormal for each patient when vital signs and fingersticks are ordered. In obtaining compliance with this indicator, the parameters for provider notification must accompany any order for testing and/or monitoring, which must also include parameter for provider notification with orders for antihypertensive medications and insulin. It is also imperative that clinical judgement and critical thinking be exercised by the nursing staff that perform these tests/monitoring to notify the provider of any abnormal findings in the absence of any parameters specified by the provider. For example, if a patient presents with a fingerstick of 400 mg/dL and there are no specific parameters accompanying the testing order that advise to notify the physician of this abnormal finding, clinical judgement would require provider notification.

Duvall Settlement Agreement Provision 20: Interaction between Medical and Custody

SA 20A: Collaboration in Patient Transport to Onsite and Off-site Appointments

Audit Methodology

The eligible audit population included patients scheduled Identify the sample population based on patients scheduled for off-site and onsite specialty care, diagnostic imaging and ER care:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There is a medical order for the test, consultation service or ER visit	100%	98%	88%	100%	88%	94%	***95%***
There is documentation of the completed consultation or medical test in EPHR with clinician's review and disposition	50%	52%	36%	48%	41%	26%	***42%***
There is documentation in EPHR of review of the ER report by the clinician following return of the detainee to the facility	0%	50%	100%	67%	100%	100%	***70%***
If there was a missed appointment, there was a documented reason for the missed appointment in EPHR	7%	11%	24%	33%	0%	38%	***19%***
If there was a missed appointment, there is documentation of rescheduled and completed appointment in EPHR	23%	0%	0%	0%	0%	50%	***12%***
Score Summary for SA 20A:	***36%***	***42%***	***50%***	***50%***	***46%***	***62%***	***48%***

Opportunities for Improvement

Clinical and operational oversight of providers and healthcare staff responsible for scheduling off-site appointments is required to ensure that the appropriate documentation is made within the health record when an appointment needs to be rescheduled, regardless of the reason. Reasons for the rescheduled appointment was not explored in detail during this reporting period. Improvement can be achieved with establishing a procedure for schedulers to communicate with providers when a scheduled appointment has been cancelled or not kept, to include notification of patient refusals and custody barriers on the same date that the appointment is scheduled. Ongoing collaboration with custody transport must continue to ensure that if the need arises to reschedule an appointment that it is done in a timely manner. Of concern, shortages in custody personnel to complete scheduled appointments was consistently noted throughout the reporting period; instances such as these must be escalated through the medical and custody chain of command for timely resolution.

SA 20B: Medically-Directed Accommodations

Audit Methodology

The eligible audit population included plaintiffs that required an accommodation outlined by the Americans with Disabilities Act of 1990, herein referenced as ADA and those detainees who had a medically initiated Transfer of Housing form. Challenges in the full reporting of this indicator is the inaccessibility of a comprehensive and accurate listing of patients that are assigned a bottom bunk for medical reasons outside of an ADA-eligible disability; limitations within the EPHR and OCMS in extracting this data was proven a barrier for this reporting period:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There is an order in EPHR for cane, crutches, wheelchair, bottom bunk, and any other disability (visual impairment, seizure, orthopedic restrictions, hearing impairment)	44%	68%	63%	63%	63%	85%	***64%***
There is a copy of a completed transfer of housing form in the medical record	100%	95%	93%	100%	100%	100%	***98%***
There is a signed receipt of durable medical equipment in the medical record for each detainee	55%	55%	61%	83%	100%	54%	***68%***
Detainees are housed in the designated areas for ADA housing (confirmed during joint custody/medical ADA rounds for patients that require ADA accommodations, and on the Inmate Traffic History in OCMS for patients that required bottom bunk who did not require an ADA accommodation)	81%	74%	70%	59%	59%	60%	***67%***
Score Summary for SA 20B:	***70%***	***73%***	***72%***	***76%***	***80%***	***75%***	***74%***

Opportunities for Improvement
The largest opportunity for improvement for this provision is the inclusion of the transfer of housing and disability assessment documentation within the patient health record. While medical/custody rounds are completed weekly at which time any missing documentation reconciled by the ADA nurse, the next step of the inclusion of this documentation within the health file remains a barrier.

SA 20C: Access to Patient Location
Through the end of the reporting period, at least 90% of healthcare staff have been provided access to OCMS. Currently workflows are in development to identify a process for OCMS access to be requested and obtained upon hire, with training modules readily accessible to healthcare staff on OCMS navigation and the location of the necessary offender information.

SA 20E: Coordination in Scheduling Sick Call and Medication Administration
The responsibilities of healthcare and custody staff in the completion of sick call and medication administration has been outlined in DPDS specific policy and procedures.

SA 20F: Heat Stratification
Weekly reporting of patient heat stratification designations are available for the applicable time frame for this audit period: July 1st though September 30th:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Weekly Heat Stratification Reports are available for the audit period	100%	100%	100%	-	-	-	***100%***
Weekly Heat Incident Reports are available for the audit period	100%	100%	100%	-	-	-	***100%***
Score Summary for SA 20F:	***100%***	***100%***	***100%***	-	-	-	***100%***

SA 20G: Heat Stratification
BCBIC is air-conditioned; temperature is maintained at a temperature above 88°F with processes in place to monitor temperatures on at least a daily basis by the custody team. Should a heat emergency be declared, patients may be transferred to the MTC infirmary.

Opportunities for Improvement
Heat stratification designations are extracted from the EPHR. Extraction of this data from the EPHR is with limitations; the report is noted with duplicate patient entries, also with multiple heat stratification designations. The weekly report requires "scrubbing" to ensure that the information disseminated to medical, custody and behavioral health teams is accurate, and that inappropriate patient transfers to other facilities within DPDS do not occur. Of note, there is one heat stratification designation that is determined by the medical provider; this requires collaboration between medical and mental health vendors to ensure that patient heat stratification is accurate and update when there is a change in the patient's status.

Duvall Settlement Agreement Provision 21: Accommodations for Plaintiffs with Disabilities

SA 21A: ADA Housing and Accommodations

Audit Methodology

The eligible audit population included all plaintiffs with a disability accommodation ***and*** required the issuance/continuance of a medical supply or other DME. This provision of the settlement agreement was audited monthly, and all (100%) of those patients that met both criteria were audited:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There is an order in EPHR for the specific medical supplies (for example colostomy bags, urinary catheter, etc.) for each detainee detailing the type and quantity	86%	67%	88%	40%	71%	88%	***73%***
There is a copy of the completed disability assessment form in the medical record.	100%	89%	100%	100%	71%	100%	***93%***
There is a copy of signed receipt for medical supplies that is consistent with order for the detainee (type and quantity)	86%	100%	100%	100%	43%	93%	***87%***
Initial medical supplies were provided within 12 to 24 hours of the order (timeliness of initiation of order)	64%	44%	33%	60%	0%	64%	***44%***
Subsequent supplies were provided consistent with the established protocol	67%	50%	83%	60%	0%	50%	***52%***
There is a copy of a completed transfer of housing form in the medical record	100%	100%	100%	100%	100%	94%	***99%***
Detainees listed on the ADA log are housed in the designated areas for ADA housing (confirmed during joint custody/medical ADA rounds)	71%	78%	88%	50%	86%	69%	***74%***
Score Summary for SA 21A:	***82%***	***75%***	***85%***	***73%***	***53%***	***80%***	***75%***

Opportunities for Improvement

Improvement is needed in the identification of ADA needs at the time of the IMMS screening by the nurse and sallyport assessment by the provider. In cases reviewed, patients have presented to the facility with canes, surgical boots, and other visible impairments in mobility and functional status that were not noted on the IMMS screening, the provider's initial physical assessment at the sallyport, or the 7-day intake examination. Some of these limitations were first addressed by the designated ADA nurse during ADA rounds, or by another healthcare staff member during another healthcare encounter addressing a different healthcare need.

Documentation indicating that the patient has received the provider-ordered medical supplies/DME was found to be documented in the healthcare record and other medical accountability logs indicating that the items were provided as ordered. However, the receipt of medical equipment that is signed by the patient and the healthcare staff was not consistently able to be located at the time of the audit. While additional copy of these forms are maintained and secured by the ADA nurse for quick reference, the location of them outside of the health file does not meet the expectation that hard copies of medical reports and documents are to be included in the hard copy of the health record, and made available to providers at the time of each healthcare encounter. Absence of these documents in the health record is attributed to a backlog of filing loose documents in the health record, and substantially impacts attainment of compliance for this indicator.

Patients that require ADA accommodations must be assigned ADA housing for the entire duration that the accommodation is required. This includes designated time in holding areas and time spent pending transfer to other facilities. In addition, when a patient is ordered the use of a cane and/or crutches, they must be maintained on their person for the duration that is indicated in the provider order. If they are housed in a housing area that precludes their possession of these items as a security risk (i.e., open dormitories), then the patient must be transferred to the designated ADA housing unit that permits continuous access to these items.

SA 21B: ADA Coordination with Medical and Custody Personnel

Oversight of the ADA efforts at BCBIC are led by representatives from the Corizon Health medical and DPDS custody teams. Both team members possess an authoritative knowledge of the DPDS Directives and DPSCS Clinical Services policies for patients with disabilities and special needs, and provide consultation to medical and custody staff on the security and medical guidelines that govern the ADA efforts in the facility.

Both staff work together to ensure that the medical and custody needs of the patients with disabilities are addressed through the implementation of weekly rounds throughout the facility. These rounds are completed with both team members present, and include physical rounds on each designated ADA housing unit, as well as each housing unit throughout the facility to ensure that there are no additional ADA accommodation requests, regardless of housing unit. During these weekly rounds, the ADA team engages the custody officers on post of the housing unit to inquire about patients with any challenges with mobility, bed assignments or other need that may indicate further investigation or assessment in whether an accommodation may be needed. During these rounds there is dialogue directly with the patients to determine if there are any unmet medical needs or any security concerns that may directly or indirectly interfere with the necessary accommodations.

It has been noted that through the reporting period, there were instances in which ADA rounds were not conducted for various reasons to include conflicting custody priorities, vacations, etc. It is recommended that when ADA rounds cannot be conducted as agreed, barriers are escalated through the medical and custody leadership for notification and resolution.

SA 21C: Access to Care for Patients that Require ADA Accommodations

Audit Methodology

The eligible audit population included all plaintiffs that required an ADA accommodation. This provision of the settlement agreement was audited monthly, and all (100%) of ADA patients were audited. The patients listed on the ADA log were cross-referenced with the sick call and chronic care, dental, mental health, and specialty appointment schedules (onsite and off-site) to determine if the patient had a healthcare appointment scheduled during the audit period:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There is documentation of encounter in EPHR for each detainee scheduled for a clinic appointment	65%	76%	85%	80%	82%	100%	***81%***
There is documentation of encounter in EPHR for all rescheduled appointments	38%	14%	25%	0%	20%	100%	***33%***
Score Summary for SA 21C:	***51%***	***45%***	***55%***	***40%***	***51%***	***100%***	***57%***

Opportunities for Improvement

Changes in the auditing of this provision from the previous reporting period was the inclusion of all appointment types for patients that require and ADA accommodation. Barriers in attending off-site and onsite specialty appointments persist, with documentation being limited that details that the encounter has occurred and if rescheduled, the appropriate documentation detailing same. Creation of a process to ensure that patients with ADA needs are attending their appointments without barriers or undue delays is imperative in demonstrating compliance with this provision.

SA 21D: ADA –Accessible Vehicle

DPDS maintains a vehicle with the requisite ADA adaptations. It is imperative that there is communication between medical and custody staff to ensure that the appropriate notification is also made when a patient requires transport from a specialty appointment and requires an accommodation that was not indicated prior to the appointment. Repairs to the vehicle must be communicated to healthcare staff should this impact appointment completion.

Duvall Settlement Provision 22: Specialty Care/Consultation

Audit Methodology

The eligible audit population included all completed specialty consultations. The sample population was selected from the off-site, onsite and ER specialty consult logs based on information entered into the CARES platform and extracted through a system data query, allowing tracking from consultation request to approval and visit completion. Appointment types were divided into 3 categories: onsite, off-site and ER visits. Sample size selection was based on 100% of completed consultations during the reporting period.

For the reporting period of July to December of CY 2019, the population audited were divided among the following categories:

		July	August	September	October	November	December	*Total*
Specialty Care Consultation types	Off-Site	18	10	16	17	10	8	***79***
	Onsite	14	16	8	7	3	3	***51***
	ER	23	10	11	5	16	5	***70***

Audit Indicators

Audit indicators were selected to evaluate EPHR documentation of the request and the time that the request has been submitted in the CARES platform though specialty visit completion:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
The Consultation Request form is completed in its entirety, with no missing pertinent information; at a minimum the following fields need completed on the Chm_consultation template in EPHR: Select off-site, onsite clinic, or telemedicine. Select urgent, routine, or Retro Request. Specialty Service Requested, Provider, Initial Visit or F/U, and Site Medical Provider?	26%	31%	43%	38%	38%	41%	**36%**
The referral processed in a timely manner? (i.e. routine referral 5 business days; urgent referral 1-2 business days; emergent referral same day; and documented in EPHR)	97%	96%	93%	90%	93%	95%	**94%**
There is evidence in the UM Log that the off-site appointment was scheduled timely after the authorization number was provided to the site (decision date on UM Log). Specialty consultation within 60 days of the authorization or within 90-120 days for less available specialties).	90%	93%	96%	96%	92%	97%	**94%**
If an ATP was received and accepted by the provider, were the ATP recommendations noted and followed up by the provider within 48 hours?	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
The site provider review the Consultation Report/Clinical Summary, provide follow-up care and document in EPHR within 48 hours	60%	63%	76%	70%	69%	74%	**69%**
The consultation report, ER discharge instructions, or hospital discharge report were signed and dated by the reviewing provider and uploaded into EPHR within 48 hours of the review date.	12%	25%	34%	15%	31%	48%	**28%**
Score Summary for SA 22:	***57%***	***62%***	***68%***	***62%***	***65%***	***71%***	***64%***

Opportunities for Improvement

The use of the CARES platform to generate consultation requests provides a clear timeline of consultation request to visit completion. While CARES provides a means to streamline the request process, communication remains essential between the ordering provider and the scheduler to ensure that the consultation requests are submitted and processed timely manner. As a manual log is still maintained at the site to track consultation requests, reconciliation between the manual logs and the outputs from the CARES platform must be reconciled regularly to ensure that all requests listed on the log have, in fact, been processed and completed. A firm system of follow-up must be implemented to ensure that appointments that are cancelled or rescheduled receive the appropriate follow-up and disposition.

Education of providers who complete consultation requests must be ongoing to ensure that the requisite information is added to the logs and all data fields are completed in their entirety, without omissions. Through review of the patient health records, there is evidence that there is dialogue between the specialty providers and site providers in ensuring that follow-up care is completed. However, the documentation from the visits is consistently omitted from the health record for review. A process to ensure that consultation requests are received from follow-up visits would support compliance for this provision.

Alternative treatment plans were not included in review of this provision, as the sample population included only those visits that were completed per the recommended audit methodology (included only completed appointments). Added benefit to perform a focused review of provider-approved alternative treatment plans would provide added insight to the full scope of specialty care needs.

SA 23A: Access to Sick Call

All patients have access to the sick call lock box on their respective housing units with an opportunity to request healthcare for urgent, emergent and routine healthcare needs on a daily basis. Emergent healthcare needs are addressed though immediate notification to healthcare staff by the custody officer on post through the internal emergency medical code response, and routine healthcare services are accessed through the processes previously described. Per BCBIC policy, any detainee that requires protective custody, administrative segregation, administrative segregation pending discipline and disciplinary segregation housing are transferred to another facility with the appropriate housing.

SA 20D, 23B, 23C and 23D: Sick Call

Audit Methodology

The eligible audit population included all sick call slips received by the medical department excluding requests for medication refills, work clearance, requests for medical records, dental needs and mental health concerns:

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Sick call slip was stamped with date and time received	65%	85%	85%	85%	73%	87%	***80%***
Sick call slip was stamped with date and time of triage	63%	77%	82%	80%	77%	82%	***77%***
The sick call slip was triaged by an RN or higher	52%	82%	87%	72%	77%	87%	***76%***
There is documentation of sick call encounter corresponding to the sick call slip complaint dated for the audit period	59%	78%	93%	95%	97%	88%	***85%***
Sick call encounter occurred within 48 hours to 72 hours (if on a weekend or holiday)	50%	50%	81%	90%	93%	79%	***74%***
If sick call appointment was missed, there is documentation of reason for missed appointment in EPHR	7%	29%	56%	57%	100%	40%	***48%***
There is documentation of an encounter in EPHR demonstrating completion of the re-scheduled/missed sick call appointment	15%	33%	33%	50%	40%	73%	***41%***
There is documentation within the encounter that identifies a physical assessment and plan that addressed the specific sick call slip complaint	37%	67%	67%	76%	81%	82%	***68%***
There is a disposition specific to the complaint identified on the sick call slip as part of the encounter note	52%	69%	77%	79%	89%	89%	***76%***
Score Summary for SA 20D, SA 23B, SA 23C and SA 23D:	***44%***	***63%***	***73%***	***76%***	***81%***	***78%***	***69%***

Opportunities for Improvement

The key to obtaining compliance is ensuring that healthcare staff are vigilant in utilization of the digital time stamp to record when sick call slips are received and triaged and that sick call slips are available for auditing. Fail safes must be implemented to ensure that the digital time stamp is functional at all times, and that there is a sufficient supply of ink cartridges to ensure that the stamps are visible on the hard copy in the health record and when copied for compliance record keeping. Nursing staff who are assigned to triage sick call slips must be consistent in documenting their credentials, with supervisory staff implementing accountability checks to ensure that this performance expectation is consistently met.

While the sick call process is a patient-initiated request for care, the largest area of improvement must be in providing supervisory oversight in ensuring that the performance expectations required by healthcare staff that participate in the pick-up, triage, scheduling and evaluation of patient health requests are maintained. Healthcare and custody teams must communicate when patients are off-site at the time that sick call appointments are scheduled. Also, healthcare staff must review the EPHR to determine if the patient is scheduled for additional healthcare

appointments adjacent to the sick call appointment; use of the scheduling feature within the EPHR can facilitate this process to ensure that provider resources are preserved for those healthcare needs that require a higher credentialed provider.

Qualitative Review of Nurse Sick Call

Efforts have been initiated to assess the qualitative component of nurse sick call beginning April 2019 to mirror the concept of the qualitative audits completed for the nursing IMMS process.

Audit Methodology

The approach used to determine the quality of nursing sick call was that of a peer review. Each calendar week, a different RN assigned to sick call during the calendar month was identified, and a sample of 10 patients of whom they saw in sick call were reviewed. Patients were identified based on the listed clinical complaint on the sick call log that would reflect a focused assessment on a specific system (i.e., upset stomach, substance abuse withdrawal, pain and/or injury) or referral to a higher level of care. Nurses were selected from both male and female facilities, as well as those nurses who may be infrequently assigned to sick call. For those staff members assigned less frequently to nursing sick call, a smaller chart selection was made based on a smaller volume being seen.

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
The correct OTC protocol has been selected for the complaint described on the sick call request	83%	100%	91%	88%	100%	96%	***94%***
Applicable vital signs (pulse ox, FSBG, PEFR), including a weight, are documented with action taken for abnormal findings (including provider notification)	57%	88%	84%	90%	94%	88%	***84%***
The nursing sick call encounter is documented in SOAP format	83%	40%	38%	38%	58%	74%	***55%***
Patient is referred appropriately to the next level provider, when indicated	90%	92%	94%	88%	89%	91%	***91%***
Patient education is documented	30%	45%	37%	30%	46%	45%	***39%***
Phone or verbal consultation with a provider is documented, as applicable	n/a	100%	100%	0%	n/a	n/a	***67%***
Score Summary for SA 23 (Quality):	***69%***	***78%***	***74%***	***56%***	***77%***	***80%***	***72%***

Opportunities for Improvement

Improvement in the qualitative aspects of nurse sick call will require a thorough review of current sick call processes and workflows. Opportunities for consistency in documentation within the EPHR, maximizing EPHR functionality of tasking and scheduling will provide significant improvement in ensuring that patients receive the appropriate clinical assessment and receive the appropriate follow-up. Strong educational initiatives are essential in validating skill sets of nurses that complete sick call to include conducting focused physical assessments, documentation, problem solving, critical thinking, using the nursing process and motivational interviewing.

Duvall Settlement Agreement, Provision #24: Medical Records

Audit Methodology

The eligible audit population included all plaintiffs that were scheduled for chronic care (CCC), nursing and mid-level provider sick call clinics, mental health, onsite specialty, and dental clinics:

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 24	There is a check mark against the name of the patients on the clinic schedule indicating the hard copy health record was pulled for all patients scheduled for that clinic	90%	90%	55%	69%	88%	73%	***78%***
	There is documentation of the encounter in the EPHR noting that the hard copy records were available and were reviewed during the specific healthcare encounter	80%	84%	39%	47%	52%	55%	***60%***
	Score Summary for SA 24:	***85%***	***93%***	***47%***	***58%***	***70%***	***64%***	***69%***

Opportunities for Improvement

Determining compliance with provision is not without its limitations, given the dynamic environment of BCBIC. While an updated electronic health record would improve the accessibility of healthcare information between healthcare disciplines and throughout the patients care continuum and period of incarceration, efforts of documenting review of available healthcare information must remain an essential component in developing an appropriate and continuous plan of care. Enhancements to the schedule template to include clear areas of documentation for the retrieval and availability of health records by medical records staff will provide beneficial in achieving compliance with this provision.

Perhaps the most critical of all opportunities for improvement lies the ongoing efforts of monitoring, responsibility and accountability of medical and mental health professionals to document the availability and review of the hard copy health record during each clinic encounter by site leadership and their supervising clinicians.

Glossary

ADA – The Americans with Disabilities Act and accompanying regulations, each of which may be amended from time to time.

ADON –Assistant Director of Nursing.

AHRQ PQI- Agency for Healthcare Research Quality Prevention Quality Indicators are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or, with early intervention, can prevent complications or more severe disease. Retrieved from www.qualityindicators.ahrq.gov.

BCBIC - Baltimore Central Booking and Intake Center.

DON – Director of Nursing.

DPDS or Division of Pre-trial Detention and Services – The unit within DPSCS responsible for operating the following facilities: BCBIC, CDF, MTC, BPFJ and YDC.

DPSCS – The Department of Public Safety and Correctional Services.

EPHR or Electronic Patient Health Record - The electronic portion of the patient's medical record that includes documentation for all Medical, Mental Health, Dental, and Pharmacy services provided to the patient

Extraordinary Care - Care rendered beyond sick call or routine illness or treatment for a chronic condition. Extraordinary Care includes, but is not limited to, all specialty care (On and Off-site), all Off-site inpatient care, treatment for Hepatitis C, all Emergency transportation and Emergency treatment, all DME (including prostheses, wheelchairs, glasses, etc.) whether temporary or permanent, dialysis (whether On or Off-site), and any special equipment required for treatment (such as special hospital beds, etc.).

Heat Stratification Category - A classification assigned to identify a patient's susceptibility to heat related illness or injury because of a medical or mental health condition or use of specified prescription medication.

Hemoglobin A1C - A form of hemoglobin which is measured primarily to identify the average plasma glucose concentration over prolonged periods of time.

IMMS - Intake Medical/Mental Health Screening form.

Infirmary - An area in a DPSCS facility from which patients are monitored and/or treated clinically for conditions that require inpatient observation and/or hospital processes that would be part of disease management, including medication administration, IV therapy, etc.

KOP - Medication(s) that patients are required to Keep-On-Person.

MAR or Medication Administration Record - A document in the patient's permanent paper medical record that serves as a legal record of the medications administered to a patient at a facility.

Mid-Level Provider: Physician's Assistant or Board Certified Advanced Practice Nurse (APRN, CRNP).

MRSA - Methicillin resistant *Staphylococcus aureus*, a bacterial infection that is highly resistant to some antibiotics.

MTC – Metropolitan Transition Center.

OCMS - The Department's computerized Offender Case Management System which includes inmate demographic and facility location information and the IMMS. OCMS is a web-based system built on .net technology and sitting on an Oracle database.

Off-site - Any location that is not onsite.

Onsite - Physically on the premises of a Department facility.

SAW- Substance abuse withdrawal.

SSRL- Sallyport Screening and Referral Log.

7-Day Intake Physical – The comprehensive physical examination of Inmates that occurs within 7 days of Inmates entering DPSCS facilities from the community.

UM or Utilization Management Program – Pre-approval process approving or denying outpatient services and Extraordinary Care.

Appendix A: Operational Definitions for Audit Indicators

SA 17A (Fit for Confinement)	IMMS is completed in OCMS within 2 hours of scan in time	A "Y" indicates that the time that the patient was scanned/received into the facility and the time that the IMMS is completed is within 2 hours as measured in the time listed in the column entitled "OCMS IMMS Date/Time" on the OCMS Migration Report. An "N" indicates that the time that the patient was scanned/received into the facility and the time that the IMMS is completed was greater than 2 hours. A "N/A" indicates that the IMMS was not completed, as the patient was released. An "Unable to validate" indicates that the scan time is later than IMMS completion date/time or the IMMS is not present in EPHR
	IMMS migrated to EPHR within 4 hours of completion	A "Y" indicates the time from IMMS completion to EPHR migration is less or equal to 4 hours. An "N" indicates that time from IMMS completion to EPHR migration is greater than 4 hours. A "N/A" indicates that EPHR migration did not occur, as the patient was released from custody or rejected. An "Unable to validate" indicates that the IMMS not present in EPHR.
	IMMS is completed by an RN or higher	A "Y" indicates that the IMMS was completed by an RN or higher. The IMMS User ID in OCMS is verified with the name and licensure (RN or higher) provided in the NetDocs file. An "N" indicates that the IMMS completed by an LPN or other lower level of licensure than an RN (including invalid/expired licensure). A "N/A" indicates that the IMMS was not completed, as the patient was released. An "Unable to validate" is not applicable to this indicator.
SA 17A (Not Fit for Confinement)	IMMS migrated to EPHR within 4 hours of completion upon return to the facility for rejects	A "Y" indicates the time that the patient was scanned/received into the facility and the time that the IMMS is completed is within 4 hours upon return to the facility. An "N" indicates that the time that the patient was scanned/received into the facility and the time that the IMMS is completed was greater than 4 hours upon return to the facility. A "N/A" indicates that the IMMS was not completed, as the patient did not return to custody. An "Unable to validate" indicates the scan time is later than IMMS completion date/time; IMMS not present in EPHR.
	Provider encounter note in EPHR following ER return	A "Y" indicates that there is an encounter note for patient made by a mid-level or higher, demonstrating an assessment was completed following ER return. An "N" indicates that there is NOT an encounter note for patient made by a mid-level or higher, demonstrating an assessment was completed following ER return. A "N/A" indicates that the IMMS was not completed, as the patient did not return to custody. An "Unable to validate" is not applicable for this indicator.

SA 17B	There is documentation on the IMMS of a referral to mental health	A "Y" indicates there is documentation on the IMMS of an urgent referral to medical and/or mental health. An "N" indicates there is no documentation on the IMMS of an urgent referral to medical. An N/A and unable to validate are not applicable to this indicator.
	There is documentation of same arrestee's name as an urgent referral on the Sallyport Screening Referral Log, same date as IMMS	A "Y" indicates there is documentation of the same arrestees name on the SSRL Log of an urgent medical and/or mental health referral, same date as IMMS. An "N" indicates there is no documentation of an urgent medical and/or mental health referral on the SSRL ***or*** the arrestee is not listed on the SSRL with an urgent disposition on the same date the IMMS was completed. An "N/A" and "unable to validate" are not applicable to this indicator.
	Medical Provider encounter for urgent referral completed within 24hrs of intake screening, or sooner if clinically indicated (measured as the difference between the "OCMS IMMS Date/Time" on the IMMS Migration Report (OCMS to EPHR) to the date and time of the provider encounter note in EPHR)	A "Y" indicates there is a documented medical provider encounter for the urgent medical and/or mental health referral is completed within 24 hours, or sooner if clinically indicated, of the intake screening. An "N" indicates there is no documented medical provider encounter for the urgent medical and/or mental referral within 24 hours, or sooner if clinically indicated, of the intake screening. A "N/A" indicates the patient is released prior to the medical provider encounter. "Unable to validate" is not applicable for this indicator.
SA 17C	There is documentation on the IMMS of an urgent or emergent referral to mental health	A "Y" indicates there is documentation on the IMMS of an urgent or emergent referral to mental health. An "N" indicates there is no documentation on the IMMS of an urgent or emergent referral to mental health. An "N/A" is not applicable to this indicator. "Unable to validate" indicates patient information cannot be located.
	There is documentation of same patient name on the urgent mental health referral log, same date as the IMMS.	A "Y" indicates the arrestee is documented on the Sallyport Screening and Referral Log (SSRL) as an urgent or emergent mental health referral on the same date as the IMMS. An "N" indicates the arrestee is not documented on the SSRL as an urgent or emergent mental health referral on the same date as the IMMS. An "N/A" or "Unable to validate" is not applicable to this indicator.
	There is a medical provider encounter for the urgent or emergent mental health need completed within 24 hours of the IMMS screening or sooner, if clinically indicated [measured as the difference between the "OCMS IMMS Date/Time" on the IMMS Migration Report (OCMS to EPHR) to the date and time of the provider encounter note in EPHR].	A "Y" indicates there is a documented medical provider encounter for the urgent or emergent mental health need that was completed within 24 hours, or sooner if clinically indicated, of the intake screening. An "N" indicates there is no documented medical provider encounter for the urgent or emergent mental health need within 24 hours, or sooner if clinically indicated, of the intake screening. An "N/A" is not applicable to this indicator. "Unable to validate" indicates the patient could not be located in the EPHR or patient released from custody prior to the provider attempting compliance with this indicator.

SA 17C	There is documentation in EPHR from the medical provider/practitioner referring the individual to the mental health provider	A "Y" indicates there is documentation in EPHR referring the arrestee to the mental health provider from the medical provider via EPHR consultation request. An "N" indicates there is no documentation in EPHR referring the arrestee to the mental health provider from the medical provider via EPHR consultation request. An "N/A" is not applicable to this indicator. "Unable to validate" indicates the patient could not be located in the EPHR or patient released from custody prior to the provider attempting compliance with this indicator.
	There is documentation of a mental health provider encounter for urgent mental health referral completed within 24 hours of medical provider/practitioner referral, or sooner if clinically indicated (measured as the difference between the medical provider/practitioner patient encounter note referring the individual to mental health and the mental health provider patient encounter note)	A "Y" indicates there is documentation in EPHR of a mental health provider encounter within 24 hours, or sooner if clinically indicated, from the medical provider patient encounter note. An "N" indicates there is no documentation in EPHR of a mental health provider patient encounter within 24 hours, or sooner if clinically indicated, from the medical provider patient encounter note. An "N/A" is not applicable to this indicator. "Unable to validate" indicates the patient could not be located in the EPHR or patient released from custody prior to the provider attempting compliance with this indicator.
SA 17D SA 17E	There is a medication order documented for any chronic care or acute medications identified/reported at IMMS or alternative medications ordered	A "Y" indicates there is a medication order for all chronic or acute medications identified during the intake receiving process and/or alternative medication prescribed. An "N" indicated there is not a medication order for all chronic or acute medications identified during the intake receiving process and/or alternative medication prescribed. "N/A" is not applicable for this indicator. "Unable to validate" indicates the patient could not be located in the EPHR or patient released from custody prior to the provider attempting compliance with this criteria.
	There is an MAR generated documenting chronic or acute medications identified during the intake receiving process (IMMS) or alternative medications ordered.	A "Y" indicates the auditor was able to locate a MAR documenting chronic or acute medications identified during the intake receiving process (IMMS) and/or alternative medication prescribed. An "N" indicates the auditor was unable to locate a MAR documenting chronic care or acute medications identified during the intake receiving process (IMMS) and/or alternative medication prescribed. "N/A" is indicated if there was no MAR generated from the provider encounter (i.e., no medications were ordered). "Unable to validate" indicates the patient could not be located in the EPHR or patient released from custody prior to the provider attempting compliance with this criteria.
	First dose of medications reported at IMMS or alternative medication ordered were administered within 24hrs of the IMMS in OCMS (measured as the difference between the "OCMS IMMS Date/Time" on the IMMS Migration (OCMS to EPHR) report to the date and time the first dose of medication was administered)	A "Y" is indicated if the first dose of medication was administered within 24 hours of intake screening. A "N" is indicated if the first dose of medication was not administered within 24 hours of intake screening or MAR did not contain administration date and time. An "N/A" is indicated if there were no medications ordered *or* there is documentation that the patient refused the first dose of medication (refusals must be documented in accordance with DPSCS Policy). "Unable to validate" is indicated if the patient could not be located

		in the EPHR or patient released from custody prior to the provider attempting compliance with this indicator.
SA 17D SA 17E	There is explanation in EPHR for non-ordered medications listed as current by the patient (alternative ordered or medication not continued)	A "Y" is indicated if there is an explanation in EPHR for non-ordered medications listed as current by the patient during the intake screening. An "N" is indicated if there is no explanation in EPHR for non-ordered medications listed as current by the patient during the intake screening. A "N/A" indicates medications listed as current by the patient during the IMMS were ordered. "Unable to validate" is indicated if the patient could not be located in the EPHR or patient released from custody prior to the provider attempting compliance with this indicator
SA 17 (Quality)	Intake Screening form is completed in its entirety with no blanks	A "yes" response for this indicator means IMMS must be completed with no blanks. A "no" response for this indicator means the IMMS contained blanks, data fields do not correlate with the notations made within the IMMS comments, or obvious signs of disability or injury noted in the provider assessment are not captured on the IMMS.
	Vital signs and peak flow (respiratory problems) and/or random finger stick glucose (diabetics) were documented	A "yes" response for this indicator means blood pressure, pulse, respirations, and temperature fields are be completed. Also, the random finger stick glucose field must be completed for diabetics or suspected diabetics, and the PEFR and pulse ox field must be completed for those with or suspected respiratory problems. A "no" response for this indicator means one or more of the required fields ***are not*** complete. Of note, weight is a free text field that is required for the IMMS and was required for credit.
	Point of Care Testing is documented on the IMMS in the comments section	A "yes" response for this indicator means the pregnancy test (age 12-65), chlamydia, gonorrhea, and RPR must be documented for females. Also, the rapid HIV test must be recorded if there is no signed refusal in the medical record. A "no" response for this indicator means one of the above test *was not* documented in the comments section on the IMMS
	Baseline CIWA or COWS scores are documented on the IMMS for all individuals who reports drug or alcohol use	A "yes" response for this indicator means the baseline CIWA or COWS score was documented on the IMMS for all individuals who reported drug or alcohol use. A "no" response for this indicator means the CIWA or COWS score was not documented on the IMMS, the incorrect scoring tool was used based on the substance used
	The individual was triaged and referred appropriated based on the nursing assessment and IMMS responses	All individuals should be referred appropriately as stated below: ***Emergently:*** Arrestees/detainees/ inmates who present with symptoms of psychosis, unstable mood, suicidal thought or behaviors, severe agitation considered not to be related to substance abuse or who exhibit other symptoms suggestive of danger to themselves or others shall be referred immediately ***Urgently:*** Arrestee/detainee/inmate reporting or determined to have active acute,

		chronic medical, mental health, substance abuse, or other conditions requiring immediate medical care shall be referred to an appropriate clinician for physical examination and treatment ***Routine:*** Arrestee/detainee/inmate does not have active acute, chronic medical, mental health, substance abuse or other conditions requiring immediate medical care A no response is also indicated for discordant disposition documentation on the IMMS and SSRL logs, as well as an incorrect selection of a disposition based on data documented.
SA 19A	Compliance with chronic care policy as shown by order in EPHR for this patient to be seen in Chronic Care Clinic for his/her previously diagnosed chronic health condition	A "Y" indicates there is documentation of order for the patient to be seen in chronic care clinic in patient encounter. It could be previous Chronic Care Clinic, Sallyport Assessment, Acuity I/Acuity II Health Assessment and/or 7-Day Intake Physical/Health Assessment. An "N" indicates there is no documented order for the patient to be seen in chronic care clinic as indicated by the provider. A "N/A" and "unable to validate" are not applicable to this indicator.
	Compliance with chronic care policy for the first appointment within 30 days or as clinically ordered as shown by EPHR review calculated as time between order date and chronic care appointment	A "Y" indicates there is documentation for patient being seen in chronic care clinics within 30 days or as clinically ordered as shown by EPHR review calculated as time between initial order date and chronic care appointment. An "N" indicates there is evidence that 30-day time period or other order was not followed. An "N/A" is not applicable to this indicator. "Unable to validate" is indicated if the patient has been released from custody prior to demonstrating compliance with this indicator.
	Ongoing compliance with chronic care clinics within 90 days or as clinically ordered shown by EPHR review calculated as time between the last chronic care encounters	A "Y" indicates there was 90-day period or less between the last two chronic care encounters or 90-days or less between the audit date and the last CC encounter; or CC encounter occurred within the time frame as ordered during the last clinician encounter. An "N" indicates that there were more than 90 days between the last two CC encounters, or more than 90 days between last CC encounter and the audit date; or the CC encounter did not occur within the time frame ordered at last clinician encounter. An "N/A" and "unable to validate" are not applicable to this indicator.
	Chronic medications ordered for 120 days as shown by the start and stop dates on the order in EPHR.	A "Y" indicates there is 120 days between the start and the stop dates of the chronic medications ordered as written in EPHR Chronic Care Encounter. An "N" indicates there is less or more than 120 days between the start and the stop dates of the chronic medications ordered as written in EPHR Chronic Care Encounter. An "N/A" indicates the patient was not in custody for at least 31 days to meet compliance with this indicator. "Unable to validate" are not applicable to this indicator.
	Start and stop dates accurately transcribed on MARs.	A "Y" indicates the start and stop dates of the medication as transcribed on the MARs matches the order in EPHR Chronic Care Encounter and shows start and stop dates. An "N" indicates start and stop dates do not match the start and stop dates in EPHR Chronic Care Encounter and/or do not show the start and stop dates. An "N/A" and

		"unable to validate" are not applicable to this indicator.
	A review of the MAR shows continuity of medications without interruption.	A "Y" indicates there is no interruption in the sequence in which the medication has been ordered. An "N" indicates there was a break in the sequence in which medications have been ordered. An "N/A" and "unable to validate" are not applicable to this indicator.
SA 19B	Medication administered by LPN or higher (confirmed by signature and licensure documented on the back of the MAR – LPN, RN, PA, NP)	A "Y" indicates that the initial of the medication administrator as documented in the block on the front of the MAR matches a printed name, signature and licensure including RN or LPN on the back of the MAR. An "N" indicates there is no matching printed name or signature on the back of the MAR, no licensure noted, or printed name and signature are non-legible. A "N/A" and "unable to validate" are not applicable to this indicator.
	Medications administered as ordered (no holes/blanks) – "N" for any hole or blank	A "Y" indicates that all medications were initialed as administered or documented as missed. An "N" indicates the block was blank with no nursing initial. A "N/A" and "unable to validate" are not applicable to this indicator.
	Missed medication documented using approved codes	A "Y" indicates that the missed dose was documented with nursing initial in the block circled and the appropriate code (for example, R for refusal) documented above or below the circled initial. If other was selected as code for missed dose, the reason was documented on the back of the MAR. An "N" indicates failure to document the missed dose as indicated above. A "N/A" and "unable to validate" are not applicable to this indicator.
	Number of blanks or holes in the MAR (number of missed doses with no explanation)	Operational Definition: any block with no initial or documentation is considered a hole/blank (this means the medication was not administered as ordered and the reason for the missed dose was not documented as required by policy). For this indicator, the auditor would count and document the total number of blanks/holes on each MAR. An "N", "N/A" and "unable to validate" are not applicable to this indicator.
	Legible name of nurses administering medications whose initials appeared on the MAR with applicable professional licensure documented at the back of each MAR	A "Y" indicates that all nurses whose initials appeared on the MAR as administering medications have legible printed names with applicable professional licensure documented on the back of each MAR. An "N" indicates the nurses 'initials on the front of the MAR has no matching printed name or legible name on the back of the MAR with Applicable signature. A "N/A" and "unable to validate" are not applicable to this indicator.
	Vital signs completed and documented as ordered in EPHR	A "Y" indicates that vital signs results were documented in EPHR as ordered. An "N" indicates that results of vital signs were not documented as ordered. Any missed occurrence results in a "N." A "N/A" is indicated for results for blood sugar testing or patient is released prior to demonstrating

SA 19C		compliance with this indicator. "Unable to validate" is not applicable for this indicator.
	Blood sugar tests completed and documented in EPHR as ordered	A "Y" indicates that blood sugar tests were completed and documented in EPHR (Chm Glucose monitor page under Patient Demographics) as ordered. An "N" means blood sugar tests were not completed and documented as ordered. Any missed occurrence results in an "N." A "N/A" is indicated for results for vital signs or patient is released prior to demonstrating compliance with this indicator. Unable to validate" is not applicable for this indicator.
SA 19C	Vital signs results documented as reviewed by clinician during patient encounter	A "Y" indicates that there is documentation in the clinician's encounter note indicating review of the vital signs results; this could be during the chronic care encounter or during any other encounter as indicated in the plan of care. An "N" means that there was no documentation of review of the vital signs results in EPHR during any of the encounters by the clinician. A "N/A" is indicated for results for blood sugar testing or patient is released prior to demonstrating compliance with this indicator. "Unable to validate" is not applicable for this indicator.
	Blood sugar tests documented as reviewed by clinician during patient encounter	A "Y" indicates that there is documentation in the clinician's encounter note indicating review of the blood sugar results; this could be during the chronic care encounter or during any other encounter as indicated in the plan of care. An "N" indicates that there was no documentation of review of the blood sugar results in EPHR during any of the encounters by the clinician. A "N/A" is indicated for vital sign results or patient is released prior to demonstrating compliance with this indicator. "Unable to validate" is not applicable for this indicator.
SA 19D	KOP medication receipt by patient documented on MAR for each KOP refill request for the most recent sick call request for review	A "Y" indicates there is documentation of receipt of requested refill on MAR for each medication requested on the sick call slip. The MAR documentation reflects the use of the designated KOP stamp, which includes staff signature, # of pills issued, KOP education given, the patient signature and date received. An "N" indicates there is no documentation (or there is partial documentation) on the MARS for the KOP medication receipt by the patient using the designated KOP stamp during the month ***or*** that there is no documentation on the MAR showing receipt of the medication requested on the sick call slip. A "N/A" and "Unable to verify" is not applicable to this indicator.
	No lapse in medication between dates refills were received by patient measured as the number of doses from last fill to the current fill	A "Y" indicates there is no lapse. An "N" indicates there is evidence of missed medication by no overlap between the last fill and the next receipt of KOP meds. A "N/A" is indicated when a refill was not requested/required (i.e., too soon to fill) or it is the first/initial KOP order. "Unable to verify" is not applicable to this indicator.

	Stock medication review	The Stock Medication Verification Process includes a confirmation that those medications listed on the Dispensary Interim Emergency Medication Listing are available. This requires an inventory of these medications to confirm that these medications are present at the time of review. The total number of medications to be provided is the denominator, and the total number of medications confirmed during the inventory is the numerator, with a percentage being calculated to determine the percentage of medications available in the medication supply room.
SA 19E	Lab requests are listed on the facility Lab Log? (Date of order, Date test drawn/completed, Date results received, Date results reviewed by provider, Date results shared with patients, and Date review was documented in health record)?	A "Y" indicates the monthly tracking log has all of the required elements noted for the resulted lab: Date of Order, Date Test drawn/completed, Date results received, Date Results reviewed by provider, Date results shared with patients, and date review was documented in the health record. An "N" indicates the monthly tracking log does not have all of the required elements noted for the resulted lab: Date of Order, Date Test drawn/completed, Date results received, Date Results reviewed by provider, Date results shared with patients, and date review was documented in the health record. A "N/A" is not applicable to this indicator.
	There is evidence that the lab test was completed within the timeframe specified in the provider's orders?	A "Y" indicates the diagnostic test was completed and documented on the lab log within the timeframe specified by the provider. (Routine= within 48 hours). An "N" indicates the diagnostic test was not completed and documented on the lab log within the timeframe specified by the provider orders. A "N/A" is applicable when the patient is released prior to demonstrating compliance with this indicator.
	Stat labs results were received within (4) hours of the draw by a nurse or higher? (exception for tests that cannot be completed within timeframe, e.g. cultures)	A "Y" indicates that STAT lab results were received from testing facility within 4 hours of the draw by a nurse or higher (based on date and time noted on lab requisition and date and time reported noted on the STAT lab result received). An "N" indicates that STAT lab results was not received from testing facility within 4 hours of the draw by a nurse or higher (based on date and time noted on lab requisition and date and time reported noted on the STAT lab result received). A "N/A" is indicated if the test was not a stat lab.
	If critical / abnormal results were noted, the provider was notified of the lab results? (Critical= Immediately (within 15 minutes of receipt), Abnormal= within same day received or within (4) hours).	A "Y" is indicated when the critical/or abnormal lab result was reported to the provider and documented in the progress notes by the reporter (Immediately (within 15 minutes) if Critical Results or within 4 hours or the same day if Abnormal Result) (measured date and time critical or abnormal lab reported to documented date and time of provider notification in progress note in EPHR by reporter). An "N" is indicated when the critical/or abnormal lab result was not reported to the provider/or documented in the progress notes by the reporter (Immediately (within 15 minutes) if Critical Results or within 4 hours or the same day if Abnormal Result) (measured date and time critical or abnormal lab reported to documented date and time of provider notification in progress note in EPHR by reporter). A "N/A" is indicated when the lab collected was had a normal result.

	There is evidence that the lab result was Reviewed, Signed, and Dated by provider within 48 hours after receipt of test results?	A "Y" is indicated when the diagnostic test result was reviewed, signed, and dated on the actual lab result by provider within 48 hours after receipt of test results (measured date and time test resulted to date and time provider signed and dated). An "N" is indicated when the diagnostic test result was not reviewed, signed, and dated on the actual lab result by provider within 48 hours after receipt of test results (measured date and time test resulted to date and time provider signed and dated). A "N/A" is not applicable to this indicator.
SA 19E SA 19F	There is evidence that reviewed labs have written provider follow-up on lab values or test results? (within 24 hours of receipt for critical and abnormal results, 48 hours of receipt for normal results)	A "Y" is indicated when reviewed labs have a written follow up plan noted in the provider progress notes on all lab values or test results receipt (within 24 hours for critical/abnormal results and 48 for normal results) in EPHR (measured date and time test resulted to date and time of note in EPHR). A "N" is indicated when Reviewed labs do not have a written follow up plan noted in the provider progress notes on all lab values or test results receipt (within 24 hours for critical/abnormal results and 48 hours for normal results) in EPHR (measured date and time test resulted to date and time of note in EPHR). A "N/A" is not applicable for this indicator.
	There is documentation the patient was notified of normal /abnormal lab results? (Routine= 7 business days, Abnormal= 24 hours of receipt of results).	A "Y" indicates there is written documentation in the progress notes that normal/ or abnormal lab/test results were discussed with the patient within 7 days for routine labs and 24 hours for abnormal (measured date and time lab resulted to date and time of patient encounter in EPHR). An "N" indicates there is not written documentation in the progress notes that normal/ or abnormal lab/test results were discussed with the patient within 7 days for routine labs and 24 hours for abnormal (measured date and time lab resulted to date and time of patient encounter in EPHR). A "N/A" is indicated when the patient was released from custody.
	The hard copy lab test result was uploaded into EPHR within 48 hours of the provider's date and signature?	A "Y" indicates the hardcopy diagnostic test result was uploaded within 48 hrs. of the provider's date and signature (measured from the date the provider signed to the Properties Encounter date and time in EPHR). An "N" indicates the hardcopy diagnostic test result was not uploaded within 48 hrs. of the provider's date and signature (measured from the date the provider signed to the Properties Encounter date and time in EPHR). A "N/A" is not applicable for this indicator.
SA 19G	There is an *active* order for blood sugar or vital signs monitoring in EPHR by the provider with parameters in the audit period	A "Y" indicates that there is a provider order for vital signs and/or blood sugar monitoring in EPHR. An "N" indicates that there is not a provider order for vital signs and/or blood sugar monitoring present in the EPHR. A "N/A" and "unable to validate" is not applicable to this indicator.
	There is documentation in the EPHR that the vital signs and /or blood sugars were taken according to the provider orders during the audit period	A "Y" indicates that there is documentation that vital signs and/or blood sugar were documented in the EPHR according to the provider order. An "N" indicates that vital signs and/or blood sugar monitoring did not occur according to the provider order in the EPHR. Any missed occurrence results in an "N". A "N/A" and "unable to validate" is not applicable to this indicator.

	Abnormal results for vital signs and /or blood sugar have documentation in EPHR with nursing referral to the clinician during the audit period	A "Y" indicates that there is documentation of nursing referral to the clinician of abnormal vital signs and/or blood sugar tests results. An "N" indicates that there was no documentation of nursing referral to the medical provider of the abnormal vital signs and/or blood sugar results in EPHR. Any missed occurrence results in an "N." A "N/A" is indicated if the vital sign/blood glucose result is normal. "Unable to validate" is not applicable to this indicator.
SA 19G	There is documentation of the review and disposition by the clinician in EPHR for abnormal readings of vital signs or accucheck as a result of that nursing referral during the audit period	A "Y" indicates that there is documentation in the clinician's encounter note indicating review of the abnormal vital signs and/or finger stick test results from the nursing referral. An "N" indicates that there was no documentation of review of the abnormal results in EPHR during any of the encounters by the clinician as a result of that nursing referral. A "N/A" is indicated if the vital sign/blood glucose result is normal. "Unable to validate" is not applicable to this indicator.
	Blood sugar tests reported in the lab contractor blood sugar report documented as reviewed in EPHR by clinician during patient encounter during the audit period	A "Y" indicates that there is documentation in the clinician's encounter note indicating review of the blood sugar results; this could be during the chronic care encounter or during any other encounter as indicated in the plan of care. An "N" indicates that there was no documentation of review of the blood sugar results in EPHR during any of the encounters by the clinician. A "N/A" is indicated if a blood sugar test is not the sample being audited. "Unable to validate" is not applicable to this indicator.
	There is abnormal A1C >9 result for the audit period during the audit period	A"Y" indicates that there is A1C >9 result for the audit period and there is documentation in the clinician's encounter note indicating review of this result. The provider review could be done during the chronic care encounter or during any other encounter as indicated in the patient's plan of care. An "N" is indicated if there is an abnormal AIC result >9, but it was not reviewed by the provider. "N/A" means that there is: a. no A1C test result for this particular patient, as test was not clinically indicated b. last result A1C is out of audit time frame c. A1C is less than 9 d. A1C testing is not indicated (anti-hypertensives)
SA 20A	There is a medical order for the test, consultation service or ER visit	A "Y" is indicated when there is documentation of a medical order for the test, consultation service or ER visit in the EPHR. An "N" is indicated when there is no documentation of a medical order for the test, consultation service or ER visit in the EPHR. "N/A" and "unable to verify" are not applicable for this indicator.
	There is documentation of the completed consultation or medical test in EPHR with clinician's review and disposition	A "Y" is indicated when there is documentation of the completed consultation or medical test in EPHR with clinician's review and disposition. An "N" is indicated when there is no documentation of the completed consultation or medical test in EPHR with clinician's review and disposition. "N/A" and "unable to verify" are not applicable for this indicator.

	There is documentation in EPHR of review of the ER report by the clinician following return of the detainee to the facility	A "Y" is indicated when there is documentation in EPHR of review of the ER report by the clinician following return of the detainee to the facility. An "N" is indicated when there is no documentation in EPHR of review of the ER report by the clinician following return of the detainee to the facility. "N/A" is indicated if there is evidence that the patient did not return to the facility after the appointment due to a release from custody. "Unable to verify" is not applicable for this indicator.
SA 20A	If there was a missed appointment, there was a documented reason for the missed appointment in EPHR	A "Y" is indicated when there is documentation in the EPHR stating the reason the appointment was missed.An "N" is indicated when there is no documentation in the EPHR stating the reason the appointment was missed. A "N/A" is indicated when the appointment was kept as scheduled. "Unable to verify" are not applicable for this indicator.
	If there was a missed appointment, there is documentation of rescheduled and completed appointment in EPHR	A "Y" is indicated when there is documentation in the EPHR of the rescheduled and completed appointment in the EPHR. An "N" is indicated when there is no documentation in the EPHR of the rescheduled and completed appointment in the EPHR. A "N/A" is indicated when the appointment was kept as scheduled. "Unable to verify" are not applicable for this indicator.
SA 20B	There is an order in EPHR for cane, crutches, wheelchair, bottom bunk, and any other disability (visual impairment, seizure, orthopedic restrictions, hearing impairment)	A "Y" for this indicator means the auditor identified an order in EPHR for the specific assistive device or durable medical equipment needed based on the need identified on the ADA log. A "N" for this indicator means the auditor was unable to identify an order in EPHR for the specific assistive device or durable medical equipment needed based on the need identified on the ADA log. A "N/A" and "Unable to Verify" are not applicable to this indicator.
	There is a copy of a completed transfer of housing form in the medical record.	A "Y" for this indicator means the auditor was able to locate a copy of a completed transfer of housing form in the medical record and the recommended accommodation is listed on the ADA log. A "N" for this indicator means the auditor was not able to locate a copy of a completed transfer of housing form in the medical record and the recommended accommodation was not listed on the ADA log. A "N/A" and "Unable to Verify" are not applicable to this indicator.
	There is a signed receipt of durable medical equipment in the medical record for each detainee.	A "Y" for this indicators means the auditor was able to locate a copy the signed recent for durable medical equipment in the medical records and the recommended accommodation is listed on the ADA log. Both must be present for a "yes" response. A "N" for this indicator means the auditor was not able to locate the signed receipt of durable medical equipment in the medical record and the recommended accommodation is listed on the ADA log. Absence of either criteria warrants a "no" response. A "N/A" is indicated when DME is not issued or required. "Unable to verify" is not applicable to this indicator.

	Detainees are housed in the designated areas for ADA housing (confirmed during joint custody/medical ADA rounds for patients that require ADA accommodations, and on the Inmate Traffic History in OCMS for patients that required bottom bunk who did not require an ADA accommodation).	A "Y" for this indicator means the auditor was able to identify verification of accommodation, by reviewing the joint custody/medical ADA rounds, consistent with identified accommodation for detainee on the ADA log. A "N" for this indicator means the auditor was unable to identify verification of accommodation, by reviewing the joint custody/medical ADA rounds, consistent with identified accommodation for all detainees on the ADA log. A "N/A" is not applicable to this indicator. "Unable to Verify" is indicated when inmate bed placement cannot be verified by the traffic history report (data field left blank in OCMS by traffic office).
SA 21A	There is an order in EPHR for the specific medical supplies or medical equipment for each patient detailing the type and quantity.	A "Y" for this indicator means the auditor identified an order in EPHR for the specific medical supply/equipment needed based on the need identified on the ADA log. A "N" for this indicator means the auditor was unable to identify an order in EPHR for the specific medical supply/equipment needed based on the need identified on the ADA log. A "N/A" and "Unable to validate" is not applicable to this indicator.
	There is a copy of the completed Disability Assessment form in the medical record.	A "Y" for this indicator means the auditor identified a completed disability form in the medical record for the disability. A "N" means the auditor was unable to identify a completed disability for in the medical records. A "N/A" for eyeglasses issued during the audit period. "Unable to validate" is not applicable to this indicator.
	There is a copy of a signed receipt for medical supplies/equipment that is consistent with order for the patient detailing type and quantity.	A "Y" for this indicator means the auditor identified a signed receipt for the specific medical supply that was ordered in audit indicator #1. A "N" for this indicator means the auditor was unable to identify a signed receipt for the specific medical supply that was ordered in audit indicator #1. "N/A" and "Unable to verify" is not applicable to this indicator.
	Initial medical supplies/equipment were provided within 12 to 24 hours of the order (timeliness of initiation of order).	A "Y" for this indicator means the auditor identified a signed receipt for the specific medical supply, identified in audit indicator #3, dated the same or next day from the order identified in audit indicator #1. A "N" for this indicator means the auditor did not identify a signed receipt for the specific medical supply, identified in audit indicator #3, dated the same or next day from the order identified in audit indicator #1. A "N/A" is applicable for eyeglasses. "Unable to verify" is not applicable to this indicator.
	Subsequent supplies were provided consistent with the established protocol (timeliness of receipt of subsequent supplies).	A "Y" for this indicator means the auditor identified a signed receipt of subsequent supplies (identified in audit indicator #3) consistent with the established protocol. A "N" for this indicator means the auditor did not identify a signed receipt for subsequent supplies (identified in audit indicator #3) consistent with the established protocol. A "N/A" is indicated if medical equipment (i.e., non-replenishable) is provided during the

		audit period. "Unable to verify" is not applicable to this indicator.
	There is a copy of a completed transfer of housing form in the medical record.	A "Y" for this indicator means the auditor was able to locate a copy of a completed transfer of housing form in the medical record and the recommended accommodation is listed on the ADA log. A "N" for this indicator means the auditor was not able to locate a copy of a completed transfer of housing form in the medical record and the recommended accommodation was not listed on the ADA log. A "N/A" and "unable to verify" is not applicable to this indicator.
SA 21A	Patients are housed in the designated areas for ADA housing (confirmed during joint custody/medical ADA rounds for patients that require ADA accommodations).	A "Y" for this indicator means the auditor was able to identify verification of accommodation, by reviewing the joint custody/medical ADA rounds, consistent with identified accommodation for detainee on the ADA log. A "N" for this indicator means the auditor was unable to identify verification of accommodation, by reviewing the joint custody/medical ADA rounds, consistent with identified accommodation for all patients on the ADA log. A "N/A" and "Unable to Verify" is not applicable to this indicator.
SA 21B	There is documentation of encounter in EPHR for each detainee scheduled for a clinic appointment.	A "Y" for this indicator means for each clinic appointment the detainee is scheduled to attend (sick call, mental health, chronic care, dental, off-site or onsite specialty) there is an encounter note in EPHR with the same date as the scheduled appointment on the corresponding log, or for each missed appointment, there is documentation in EPHR of reason for the missed appointment with the same date as the scheduled appointment on the corresponding log. A "N" for this indicator means for each clinic appointment the detainee is scheduled to attend (sick call, mental health, chronic care, dental, off-site or onsite specialty) there is no EPHR encounter note with the same date as the scheduled appointment on the corresponding log, or for each missed appointment, there is no documentation in EPHR of reason for missed appointment with the same date as the scheduled appointment on the corresponding log. A "N/A" is indicated if the appointment was rescheduled or the patient was released prior to the appointment. "Unable to verify" is not applicable to this indicator.

	There is documentation of encounter in EPHR for all rescheduled appointment.	A "Y" for this indicator means for each clinic appointment the detainee missed from audit indicator #1 (sick call, mental health, chronic care, dental, off-site or onsite specialty) there is an encounter note in EPHR for the rescheduled appointment corresponding to the missed appointment as documented in indicator #1. An "N" for this indicator means for each clinic appointment the detainee missed from Audit indicator #1 (sick call, mental health, chronic care, dental, off-site or onsite specialty) there is no note in EPHR corresponding to the rescheduled appointment in indicator #1. A "N/A" is indicated if the appointment was completed as scheduled. "Unable to verify" is not applicable to this indicator.
SA 22	The Consultation Request form is completed in its entirety, with no missing pertinent information; at a minimum the following fields need completed on the Chm_consultation template in EPHR: Select off-site, onsite clinic, or telemedicine. Select urgent, routine, or Retro Request. Specialty Service Requested, Provider, Initial Visit or F/U, and Site Medical Provider?	A "yes" response for this indicator means the Consultation Request Form (Referral Request Form) is completed completely with no missing information. At a minimum the following fields need completed on the Chm_consultation template in EPHR: Select off-site, onsite clinic, or telemedicine. Select urgent, routine, or Retro Request. Specialty Service Requested, Provider, Initial Visit or F/U, and Site Medical Provider A "no" response for this indicator means the consultation request form is not completed or is missing information any of the minimum specifications.
	The referral processed in a timely manner? (i.e. routine referral 5 business days; urgent referral 1-2 business days; emergent referral same day; and documented in EPHR)	A "yes" response for this indicator means the referral was processed in 5 business days for routine referrals, 24 to 48 hours for urgent referrals, or same day if emergent. AND the disposition documented in EPHR. A "no" response for this indicator means the referral was not processed appropriately per the specified category timeframe or was not documented into EPHR.
	There is evidence in the UM Log that the off-site appointment was scheduled timely after the authorization number was provided to the site (decision date on UM Log). Specialty consultation within 60 days of the authorization or within 90-120 days for less available specialties).	A "yes" response for this indicator means there is documentation in the UM Log the off-site appointment was scheduled timely after the authorization number was provided to the site (decision date on UM Log) as defined as 60 days for specialty consultations or within 90-120 days for less available specialties. A "no" response for this indicator means there is no documentation the off-site appointment was scheduled timely per the specified category timeframe.
	If an ATP was received and accepted by the provider, were the ATP recommendations noted and followed up by the provider within 48 hours?	A "yes" response for this indicator means that if the Alternative Treatment Plan was received, the alternative treatment plan recommendations were documented in EPHR AND followed-up by the provider within 48 hours of receipt of the alternative treatment plan as found in the Notes section in CARES. A "no" response for this indicator means that if the Alternative Treatment Plan was received AND accepted by the provider, the alternative treatment plan recommendations were not documented or followed-up by the provider within 48 hours.

SA 22	The site provider review the Consultation Report/Clinical Summary, provide follow-up care and document in EPHR within 48 hours	A "yes" response for this indicator means the site provider reviewed the Consultation Report/Clinical Summary AND provided follow-up care. AND documented the review with an integrated plan of care in EPHR within 48 hours of receiving the consult report or discharge instructions. A "no" response for this indicator means the site provider did not review the consultation report/clinical summary or provide follow-up care or was not documented in EPHR within 48 hours of receiving the consult report or discharge instructions.
	The consultation report, ER discharge instructions, or hospital discharge report were signed and dated by the reviewing provider and uploaded into EPHR within 48 hours of the review date.	A "yes" response for this indicator means the consultation report, ER discharge instructions, or hospital discharge report were signed AND dated by the reviewing provider AND uploaded into EPHR within 48 hours of the review date. A "no" response for this indicator means the consultation report, ER discharge instructions, or hospital discharge report was not signed or dated by the reviewing provider AND uploaded into EPHR within 48 hours of the review date.
SA 20D SA 23B SA 23C SA 23D	Sick call slip was stamped with date and time received.	A "Y" indicates the automated date and time of sick call receipt was present on the left upper side of the sick call slip. An "N" indicates the automated date and time of sick call receipt on the left upper side of the sick call slip was not present. A "N" is also indicated if the sick call slip cannot be located. A "N/A" and "unable to verify" was not applicable to this indicator.
	Sick call slip was stamped with date and time of triage.	A "Y" indicates the medical triage section of the sick call slip includes the automated date and time of triage on the upper right side sick call slip. An "N" indicates the medical triage section of the sick call slip does not include the date and time of triage on the sick call slip. A "N" is also indicated if the sick call slip cannot be located. A "N/A" and "unable to verify" was not applicable to this indicator.
	The sick call slip was triaged by an RN or higher	A "Y" indicates the medical triage section of the sick call slip includes the legible signature and credentials of the RN completing the sick call triage. A "N" means the medical triage section of the sick call slip does not include the legible signature and/or credentials of the RN completing the sick call triage. A "N" is also indicated if the sick call slip cannot be located. A "N/A" and "unable to verify" was not applicable to this indicator.
	There is documentation of sick call encounter corresponding to the sick call slip complaint dated for the audit period.	A "Y" indicates there is documentation within the EPHR that corresponds to the complaint listed on the sick call slip (if available, or sick call log for cases with a missing sick call slip). An "N" indicates there is no documentation within the EPHR that corresponds to the complaint listed on the sick call slip (if available, or sick call log for cases with a missing sick call slip). A "N/A" indicates the patient refused the sick call, it was rescheduled, the patient has already been seen by a provider/nurse, or has been released from custody prior to demonstrating compliance with this indicator. "Unable to verify" was not applicable to this indicator.

SA 20D SA 23B SA 23C SA 23D	Sick call encounter occurred within 48 hrs. (72 hrs. if on a weekend or holiday)	A "Y" indicates there is a documented sick call encounter within the EPHR from the automated date and time of pick-up on the sick call slip or sick call log (for cases with a missing sick call slip) that the sick call was completed within 48 to 72 hours of receipt by healthcare staff. The date and time stamp that the sick call request was received is compared to the date and time that the sick call request was completed. This time cannot exceed 48 hours (72 hours on a weekend or holiday). An "N" indicates there is not a documented sick call encounter within the EPHR from the automated date and time of pick-up on the sick call slip or sick call log (for cases with a missing sick call slip) that the sick call was completed within 48 to 72 hours of receipt by healthcare staff. The date and time stamp that the sick call request was received is compared to the date and time that the sick call request was completed. This time cannot exceed 48 hours (72 hours on a weekend or holiday). A "N/A" indicates the patient refused the sick call, it was rescheduled, the patient has already been seen by a provider/nurse, or has been released from custody prior to demonstrating compliance with this indicator. "Unable to verify" was not applicable to this indicator.
	If sick call appointment was missed, there is documentation of reason for missed appointment in EPHR.	A "Y" indicates there is documentation within the EPHR describing the reason for the missed appointment. This is not indicated for "no shows." An "N" indicates there is no documentation within the EPHR describing the reason for the missed appointment or the provider documented "no show" in the encounter. A "N/A" indicates the sick call was completed as initially scheduled. "Unable to verify" was not applicable to this indicator.
	There is documentation of an encounter in EPHR demonstrating completion of the re-scheduled/missed sick call appointment.	A "Y" indicates there is documentation within the EPHR that the missed sick call was addressed in an encounter note in the EPHR during the next scheduled clinic. An "N" indicates there is no documentation within the EPHR that the missed sick call was addressed in an encounter note in the EPHR during the next scheduled clinic. A "N/A" indicates the sick call was completed as initially scheduled. "Unable to verify" was not applicable to this indicator.
	There is documentation within the encounter that identifies a physical assessment and plan that addressed the specific sick call slip complaint.	A "Y" indicates there is documentation within the encounter that identified that a physical assessment and plan addresses the complaint noted on the sick call slip or sick call log (for cases with a missing sick call slip). An "N" indicates there is no documentation within the encounter that identified that a physical assessment and plan addresses the complaint noted on the sick call slip or sick call log (for cases with a missing sick call slip). A "N/A" indicates the patient refused the sick call, it was rescheduled, the patient has already been seen by a provider/nurse, or has been released from custody prior to demonstrating compliance with this indicator. "Unable to verify" was not applicable to this indicator.

SA 20D SA 23B SA 23C SA 23D	There is a disposition specific to the complaint identified on the sick call slip as part of the encounter note (conditions worse, improved, unchanged, or new). .	A "Y" indicates there is resolution of the problem or follow-up instructions documented in the sick call encounter in EPHR or if follow-up by another provider is required, there is documentation in the EPHR demonstrating that the follow-up encounter occurred. An "N" indicates there is no resolution of the problem or follow-up instructions documented in the sick call encounter in EPHR. If follow-up by another provider is required, there was no documentation in the EPHR demonstrating that the follow-up encounter occurred. A "N/A" indicates the patient refused the sick call, it was rescheduled, the patient has already been seen by a provider/nurse, or has been released from custody prior to demonstrating compliance with this indicator. "Unable to verify" was not applicable to this indicator
SA 23 (Quality)	The correct OTC protocol has been selected for the complaint described on the sick call request	A "yes" response for this indicator means the correct nursing OTC protocol medication was provided for the sick call complaint. A "no" response for this indicator means the nursing protocol was not followed.
	Applicable vital signs (pulse ox, FSBG, PEFR), including a weight, are documented with action taken for abnormal findings (including provider notification)	A "yes" response for this indicator means the vital signs (temperature, pulse, respiration & blood pressure) and weight is documented on the date of the encounter in EPHR MD Chm Home Vital Sign section in EPHR. A "no" response for this indicator means the vital signs and weight was not documented on the date of the encounter in EPHR MD Chm Home Vital Sign section in EPHR.
	The nursing sick call encounter is documented in SOAP format	A "yes" response for this indicator means the encounter is documented in EPHR using the Nursing Protocol template or Nurse Sick Call Scheduled/Unscheduled template using a SOAP format and has a physical assessment and plan that addresses the specific sick call complaint. A "no" response for this indicator means the encounter was not documented in EPHR using the Nursing Protocol template or Nurse Sick Call Scheduled/Unscheduled template using a SOAP format and/or was missing a physical assessment and plan that addresses the specific sick call complaint.
	Patient is referred appropriately to the next level provider, when indicated	A "yes" response for this indicator means the patient was referred appropriately to the next level provider due to serious health problems or complaint merits a visit to the next level provider; abnormal vital signs; or the individual was evaluated three times by a specific level provider for the same complaint. A "no" response for this indicator means the patient was not referred appropriately.
SA 23 (Quality)	Patient education is documented	A "yes" response for this indicator means the nurse documented how and what education was provided to the patient. A "no" response for this indicator means the nurse did not document how and what education was provided to the patient.
	Phone or verbal consultation with a provider is documented, as applicable	A "yes" response for this indicator means a phone or verbal consultation with a provider was required and was documented. A "no" response for this indicator means a phone or verbal consultation with a provider was required and was not documented.

SA 24	There is a check mark against the name of the patients on the clinic schedule indicating the hard copy health record was pulled for all patients scheduled for that clinic	A "yes" response indicates that a check mark appeared in front of the inmate's name listed on the clinic schedule. This indicates that the hard copy health record was pulled and provided to the healthcare professional for that clinic session. A "no" response indicates that there was no check mark against the name of the patient listed on the clinic schedule. This indicated that the hard copy of the health record was not made available to the healthcare professional for that clinic encounter.
	There is documentation of the encounter in the EPHR noting that the hard copy records were available and were reviewed during the specific healthcare encounter	A "yes" response indicates that the healthcare professional conducting the clinic documented that the hard copy medical record was reviewed. The provider documenting in the encounter must document "*hard copy reviewed.*" This phrase must be documented as the last sentence within the reason for visit section of the electronic health record. A "no" response indicates that the required documentation was not noted within the encounter note regarding the availability of the hard copy health record.

Appendix B: Duvall Audit Score Summary: CY 2019 July 2019 – December 2019

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 17A (Accept)	IMMS is completed within 2 hours of scan-in time	89%	100%	95%	95%	97%	98%	***97%***
	IMMS migrated to the EPHR within 4 hours of scan-in time	72%	83%	71%	80%	72%	69%	***75%***
	IMMS completed by an RN or higher	100%	100%	100%	100%	100%	100%	***100%***
	Score Summary for SA 17A (Accept)	***87%***	***94%***	***89%***	***92%***	***90%***	***89%***	***90%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 17A (Reject)	IMMS migrated to EPHR within 4 hrs of scan-in time upon return to the facility for rejects	39%	80%	87%	69%	73%	60%	***68%***
	IMMS is completed by an RN or higher	96%	100%	100%	100%	100%	100%	***99%***
	Provider encounter note in EPHR following ER return	83%	64%	88%	80%	95%	100%	***85%***
	Score Summary for SA 17A (Reject):	***73%***	***81%***	***92%***	***83%***	***89%***	***87%***	***84%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 17B	There is documentation on the IMMS of an urgent medical and/or mental health referral	92%	85%	91%	95%	93%	89%	***91%***
	There is documentation of same arrestee's name as an urgent referral on the IMMS Referral Log, same date as IMMS	100%	100%	100%	100%	100%	95%	***91%***
	Medical Provider encounter for urgent referral completed within 24 hours of intake screening, or sooner if clinically indicated	90%	92%	91%	98%	96%	96%	***94%***
	Score Summary for SA 17B:	***94%***	***92%***	***94%***	***98%***	***96%***	***93%***	***95%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 17C	There is documentation on the IMMS of an urgent or emergent referral to mental health	97%	78%	66%	79%	70%	58%	***75%***
	There is documentation of same arrestees name on the urgent mental health referral log, same date as the IMMS	64%	64%	52%	36%	41%	23%	***47%***
	There is a medical provider encounter for the urgent or emergent mental health need completed within 24 hours of the intake screening or sooner, if clinically indicated	81%	81%	79%	96%	98%	100%	***89%***
	There is documentation in EPHR from the medical provider referring the individual to the mental health provider.	87%	68%	78%	90%	83%	96%	***84%***
	There is documentation of a mental health provider encounter for urgent mental health referral completed within 24 hours of medical provider referral, or sooner if clinically indicated	96%	93%	67%	57%	40%	38%	***65%***
	Score Summary for SA 17C:	***85%***	***77%***	***68%***	***71%***	***66%***	***63%***	***72%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 17D SA 17E	There is medication order documented for any chronic care or acute medications identified/reported at IMMS or alternative medications ordered	88%	100%	96%	95%	97%	100%	***96%***
	There is a MAR generated documenting chronic or acute medications identified during the intake receiving process (IMMS) or alternative medications ordered	77%	32%	52%	51%	79%	77%	***61%***
	First dose medications reported as IMMS or alternative medication ordered were administered within 24hs of the IMMS in OCMS	59%	32%	35%	21%	59%	52%	***43%***
	There is explanation in EPHR for non-ordered medications listed as current by the arrestee	87%	100%	100%	100%	100%	86%	***95%***
	Score Summary for SA 17D & SA 17E:	***78%***	***66%***	***71%***	***67%***	***84%***	***79%***	***74%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 17 Quality	Intake Screening form is completed in its entirety with no blanks	78%	95%	90%	73%	70%	83%	***82%***
	Vital signs and peak flow (respiratory problems) and/or random finger stick glucose (diabetics) were documented	59%	87%	58%	63%	73%	83%	***71%***
	Point of Care Testing is documented on the IMMS in the comments section	59%	51%	50%	42%	70%	61%	***56%***
	Baseline CIWA or COWS scores are documented on the IMMS for all individuals who reports drug or alcohol use	76%	75%	32%	71%	39%	45%	***56%***
	The individual was triaged and referred appropriated based on the nursing assessment and IMMS responses	70%	67%	95%	88%	70%	61%	***75%***
	Score Summary for SA 17 Qualitative:	***68%***	***75%***	***65%***	***67%***	***64%***	***66%***	***68%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 18	Do the CC Encounters address the specific problems identified at the 7 day Intake Exam (excluding those issue that are resolved/inactive)?	100%	60%	100%	86%	100%	100%	***91%***
	Are needs for disease-specific lab test monitoring evaluated, reviewed, or ordered?	100%	57%	71%	100%	83%	80%	***82%***
	Is compliance with chronic medications and or diets assessed as part of the Plan of Care?	100%	0%	80%	83%	60%	75%	***66%***
	Is there indication that the chart summary and the hard copy medical record was reviewed?	71%	57%	88%	100%	78%	100%	***82%***
	Have episodic recurrent non serious medical problems been assessed with a plan of care?	67%	100%	100%	100%	100%	100%	***95%***
	Do Intake Screening encounters reflect appropriate CC registration status (with updating or enrollment where applicable) and scheduling for CC encounter(s)?	78%	100%	89%	60%	100%	88%	***86%***
	Are newly identified CC conditions updated to the Problems List?	57%	100%	50%	71%	75%	80%	***72%***
	Is the disease activity and control clearly indicated in the Plan of Care?	100%	100%	100%	100%	100%	100%	***100%***
	Is review of external specialty care and hospital or Infirmary summary /reports and recommendations clearly documented?	40%	50%	67%	67%	71%	60%	***59%***
	Score Summary for SA 18:	***79%***	***69%***	***83%***	***85%***	***85%***	***87%***	***81%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 19A	Compliance with chronic care policy as shown by order in EPHR for this patient to be seen in Chronic Care Clinic for his/her previously diagnosed chronic health condition	82%	74%	92%	55%	92%	97%	***82%***
	Compliance with chronic care policy for the first appointment within 30 days or as clinically ordered as shown by EPHR review calculated as time between order date and chronic care appointment	77%	57%	71%	41%	62%	74%	***64%***
	Ongoing compliance with chronic care clinics within 90 days or as clinically ordered shown by EPHR review calculated as time between the last chronic care encounters	67%	38%	60%	16%	33%	55%	***45%***
	Chronic medications ordered for 120 days as shown by the start and stop dates on the order in EPHR	66%	42%	66%	34%	60%	65%	***56%***
	Start and stop dates accurately transcribed on MARs	43%	40%	44%	25%	49%	62%	***44%***
	A review of the MAR shows continuity of medications without interruption	41%	32%	90%	60%	74%	82%	***63%***
	Score Summary for SA 19A:	***63%***	***47%***	***71%***	***39%***	***62%***	***72%***	***60%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 19B	Medication administered by LPN or higher (confirmed by signature and licensure documented on the back of the MAR – LPN, RN, PA, NP)	11%	12%	46%	20%	38%	46%	***29%***
	Medications administered as ordered (no holes/blanks) – "N" for any hole or blank	83%	35%	92%	55%	57%	85%	***68%***
	Missed medication documented using approved codes	71%	52%	61%	30%	51%	63%	***55%***
	Number of blanks or holes in the MAR (number of missed doses with no explanation)	127	173	6	38	103	26	***79***
	Legible name of nurses administering medications whose initials appeared on the MAR with applicable professional licensure documented at the back of each MAR	90%	80%	95%	65%	91%	95%	***86%***
	Score Summary for SA 19B:	***64%***	***45%***	***74%***	***43%***	***59%***	***72%***	***57%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 19C	Vital signs completed and documented as ordered in EPHR	8%	4%	18%	7%	8%	0%	***8%***
	Blood sugar tests completed and documented in EPHR as ordered	100%	13%	0%	0%	0%	29%	***24%***
	Vital signs results documented as reviewed by clinician during patient encounter	6%	8%	10%	20%	5%	11%	***10%***
	Blood sugar tests documented as reviewed by clinician during patient encounter	n/a	86%	75%	n/a	17%	86%	***66%***
	Score Summary for SA 19C:	***38%***	***27%***	***26%***	***9%***	***7%***	***31%***	***23%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 19D	KOP medication receipt by patient documented on MAR for each KOP refill request for the most recent sick call request for review	40%	42%	14%	9%	0%	17%	***20%***
	No lapse in medication between dates refills were received by patient measured as the number of doses from last fill to the current fill	45%	38%	50%	14%	61%	86%	***49%***
	Score Summary for SA 19D:	***43%***	***40%***	***32%***	***12%***	***31%***	***51%***	***35%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 19D	Stock medication supply availability	No data	No data	95%	90%	94%	96%	***94%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 19E SA 19F	Lab requests are listed on the facility Lab Log? (Date of order, Date test drawn/completed, Date results received, Date results reviewed by provider, Date results shared with patients, and Date review was documented in health record)?	0%	0%	0%	0%	0%	0%	***0%***
	There is evidence that the lab test was completed within the timeframe specified in the provider's orders?	13%	67%	91%	77%	46%	48%	***57%***
	Stat labs results were received within (4) hours of the draw by a nurse or higher? (exception for tests that cannot be completed within timeframe, e.g. cultures)	n/a	n/a	n/a	n/a	n/a	0%	***0%***
	If critical / abnormal results were noted, the provider was notified of the lab results? (Critical= Immediately (within 15 minutes of receipt), Abnormal= within same day received or within (4) hours)	7%	50%	30%	67%	27%	60%	***40%***
	There is evidence that the lab result was Reviewed, Signed, and Dated by provider within 48 hours after receipt of test results?	13%	75%	60%	55%	46%	42%	***49%***
	There is evidence that reviewed labs have written provider follow-up on lab values or test results? (within 24 hours of receipt for critical and abnormal results, 48 hours of receipt for normal results)	10%	100%	60%	33%	38%	32%	***46%***
	There is documentation the patient was notified of normal /abnormal lab results? (Routine= 7 business days, Abnormal= 24 hours of receipt of results).	9%	50%	22%	25%	0%	21%	***21%***
	The hard copy lab test result was uploaded into EPHR within 48 hours of the provider's date and signature?	0%	0%	0%	0%	46%	53%	***17%***
	Score Summary for SA 19E and SA 19F:	***10%***	***68%***	***53%***	***51%***	***40%***	***41%***	***44%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 19G	There is an order for blood sugar or vital signs monitoring in EPHR by the provider with parameters in the audit period	26%	17%	34%	10%	6%	12%	***18%***
	There is documentation in the EPHR that the vital signs and /or blood sugars were taken according to the provider orders during the audit period	12%	13%	2%	2%	3%	2%	***7%***
	Abnormal results for vital signs and /or blood sugar have documentation in EPHR with nursing referral to the clinician during the audit period	24%	22%	35%	83%	0%	13%	***30%***
	There is documentation of the review and disposition by the clinician in EPHR for abnormal readings of vital signs or accucheck as a result of that nursing referral during the audit period	13%	14%	24%	50%	0%	0%	***17%***
	Blood sugar tests reported in the lab contractor blood sugar report documented as reviewed in EPHR by clinician during patient encounter during the audit period	23%	21%	76%	50%	100%	40%	***52%***
	There is abnormal A1C >9 result for the audit period during the audit period	45%	7%	60%	100%	0%	100%	***52%***
	Score Summary for SA 19G:	***24%***	***15%***	***39%***	***49%***	***18%***	***28%***	***29%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 20A	There is a medical order for the test, consultation service or ER visit	100%	98%	88%	100%	88%	94%	***95%***
	There is documentation of the completed consultation or medical test in EPHR with clinician's review and disposition	50%	52%	36%	48%	41%	26%	***42%***
	There is documentation in EPHR of review of the ER report by the clinician following return of the detainee to the facility	0%	50%	100%	67%	100%	100%	***70%***
	If there was a missed appointment, there was a documented reason for the missed appointment in EPHR	7%	11%	24%	33%	0%	38%	***19%***
	If there was a missed appointment, there is documentation of rescheduled and completed appointment in EPHR	23%	0%	0%	0%	0%	50%	***12%***
	Score Summary for SA 20A:	***36%***	***42%***	***50%***	***50%***	***46%***	***62%***	***48%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 20B	There is an order in EPHR for cane, crutches, wheelchair, bottom bunk, and any other disability (visual impairment, seizure, orthopedic restrictions, hearing impairment)	44%	68%	63%	63%	63%	85%	***64%***
	There is a copy of a completed transfer of housing form in the medical record	100%	95%	93%	100%	100%	100%	***98%***
	There is a signed receipt of durable medical equipment in the medical record for each detainee	55%	55%	61%	83%	100%	54%	***68%***
	Detainees are housed in the designated areas for ADA housing (confirmed during joint custody/medical ADA rounds for patients that require ADA accommodations, and on the Inmate Traffic History in OCMS for patients that required bottom bunk who did not require an ADA accommodation)	81%	74%	70%	59%	59%	60%	***67%***
	Score Summary for SA 20B:	***70%***	***73%***	***72%***	***76%***	***80%***	***75%***	***74%***

SA 20C	There are no audit indicators associated with this provision. Source documents (e.g., daily offender rosters) received for this reporting period are maintained electronically as supporting documentation for this provision.

SA 20E	There are no audit indicators associated with this provision. BCBIC is air-conditioned.

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 20F	Weekly Heat Stratification Reports are available for the audit period	100%	100%	100%	-	-	-	***100%***
	Weekly Heat Incident Reports are available for the audit period	100%	100%	100%	-	-	-	***100%***
	Score Summary for SA 20F:	***100%***	***100%***	***100%***	-	-	-	***100%***

SA 20G	There are no audit indicators associated with this provision.

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 21A	There is an order in EPHR for the specific medical supplies (for example colostomy bags, urinary catheter, etc.) for each detainee detailing the type and quantity	86%	67%	88%	40%	71%	88%	***73%***
	There is a copy of the completed disability assessment form in the medical record.	100%	89%	100%	100%	71%	100%	***93%***
	There is a copy of signed receipt for medical supplies that is consistent with order for the detainee (type and quantity)	86%	100%	100%	100%	43%	93%	***87%***
	Initial medical supplies were provided within 12 to 24 hours of the order (timeliness of initiation of order)	64%	44%	33%	60%	0%	64%	***44%***
	Subsequent supplies were provided consistent with the established protocol	67%	50%	83%	60%	0%	50%	***52%***
	There is a copy of a completed transfer of housing form in the medical record	100%	100%	100%	100%	100%	94%	***99%***
	Detainees listed on the ADA log are housed in the designated areas for ADA housing (confirmed during joint custody/medical ADA rounds)	71%	78%	88%	50%	86%	69%	***74%***
	Score Summary for SA 21A:	***82%***	***75%***	***85%***	***73%***	***53%***	***80%***	***75%***

SA 21B	There are no audit indicators associated with this provision.

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 21C	There is documentation of encounter in EPHR for each detainee scheduled for a clinic appointment	65%	76%	85%	80%	82%	100%	***81%***
	There is documentation of encounter in EPHR for all rescheduled appointments	38%	14%	25%	0%	20%	100%	***33%***
	Score Summary for SA 21C:	***51%***	***45%***	***55%***	***40%***	***51%***	***100%***	***57%***

SA 21D	There are no audit indicators associated with this provision. Source documents (e.g., ADA logs, transport logs) received for this reporting period are maintained electronically as supporting documentation for this provision.

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 22	The Consultation Request form is completed in its entirety, with no missing pertinent information; at a minimum the following fields need completed on the Chm_consultation template in EPHR: Select off-site, onsite clinic, or telemedicine. Select urgent, routine, or Retro Request. Specialty Service Requested, Provider, Initial Visit or F/U, and Site Medical Provider?	26%	31%	43%	38%	38%	41%	**36%**
	The referral processed in a timely manner? (i.e. routine referral 5 business days; urgent referral 1-2 business days; emergent referral same day; and documented in EPHR)	97%	96%	93%	90%	93%	95%	**94%**
	There is evidence in the UM Log that the off-site appointment was scheduled timely after the authorization number was provided to the site (decision date on UM Log). Specialty consultation within 60 days of the authorization or within 90-120 days for less available specialties).	90%	93%	96%	96%	92%	97%	**94%**
	If an ATP was received and accepted by the provider, were the ATP recommendations noted and followed up by the provider within 48 hours?	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	The site provider review the Consultation Report/Clinical Summary, provide follow-up care and document in EPHR within 48 hours	60%	63%	76%	70%	69%	74%	**69%**
	The consultation report, ER discharge instructions, or hospital discharge report were signed and dated by the reviewing provider and uploaded into EPHR within 48 hours of the review date.	12%	25%	34%	15%	31%	48%	**28%**
	Score Summary for SA 22:	***57%***	***62%***	***68%***	***62%***	***65%***	***71%***	***64%***

SA 23A	There are no audit indicators associated with this provision. DPDS memorandum is maintained electronically as supporting documentation for this provision.

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 20D SA 23B SA 23C SA 23D	Sick call slip was stamped with date and time received	65%	85%	85%	85%	73%	87%	***80%***
	Sick call slip was stamped with date and time of triage	63%	77%	82%	80%	77%	82%	***77%***
	The sick call slip was triaged by an RN or higher	52%	82%	87%	72%	77%	87%	***76%***
	There is documentation of sick call encounter corresponding to the sick call slip complaint dated for the audit period	59%	78%	93%	95%	97%	88%	***85%***
	Sick call encounter occurred within 48 hours to 72 hours (if on a weekend or holiday)	50%	50%	81%	90%	93%	79%	***74%***
	If sick call appointment was missed, there is documentation of reason for missed appointment in EPHR	7%	29%	56%	57%	100%	40%	***48%***
	There is documentation of an encounter in EPHR demonstrating completion of the re-scheduled/missed sick call appointment	15%	33%	33%	50%	40%	73%	***41%***
	There is documentation within the encounter that identifies a physical assessment and plan that addressed the specific sick call slip complaint	37%	67%	67%	76%	81%	82%	***68%***
	There is a disposition specific to the complaint identified on the sick call slip as part of the encounter note	52%	69%	77%	79%	89%	89%	***76%***
	Score Summary for SA 20D, SA 23B, SA 23C and SA 23D:	***44%***	***63%***	***73%***	***76%***	***81%***	***78%***	***69%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 23 (Quality)	The correct OTC protocol has been selected for the complaint described on the sick call request	83%	100%	91%	88%	100%	96%	***94%***
	Applicable vital signs (pulse ox, FSBG, PEFR), including a weight, are documented with action taken for abnormal findings (including provider notification)	57%	88%	84%	90%	94%	88%	***84%***
	The nursing sick call encounter is documented in SOAP format	83%	40%	38%	38%	58%	74%	***55%***
	Patient is referred appropriately to the next level provider, when indicated	90%	92%	94%	88%	89%	91%	***91%***
	Patient education is documented	30%	45%	37%	30%	46%	45%	***39%***
	Phone or verbal consultation with a provider is documented, as applicable	n/a	100%	100%	0%	n/a	n/a	***67%***
	Score Summary for SA 23 (Quality):	***69%***	***78%***	***74%***	***56%***	***77%***	***80%***	***72%***

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 24	There is a check mark against the name of the patients on the clinic schedule indicating the hard copy health record was pulled for all patients scheduled for that clinic	90%	90%	55%	69%	88%	73%	***78%***
	There is documentation of the encounter in the EPHR noting that the hard copy records were available and were reviewed during the specific healthcare encounter	80%	84%	39%	47%	52%	55%	***60%***
	Score Summary for SA 24:	***85%***	***93%***	***47%***	***58%***	***70%***	***64%***	***69%***