EXHIBIT 4

DUVALL SETTLEMENT AGREEMENT REPORT

March 2, 2020

MICHAEL PUISIS, DO

OVERVIEW

The responsibilities of the medical monitor for this agreement does not include a report except when the Commissioner has asserted substantial compliance in an applicable provision of the Settlement Agreement. However, Plaintiffs' counsel requested that I provide an ongoing report irrespective of the status of compliance. Believing that production of reports would assist Defendants to organize their efforts, I agreed to do this. It was delayed due to my awaiting word from the State's counsel that the reports would be protected from subpoena.

The report will include a brief executive summary. Each provision of the report will be stated verbatim in italics as a Settlement Agreement Statement. Following that I will give a compliance rating for that item. Although the Settlement Agreement does not define compliance ratings, including substantial compliance, I will use the compliance rating to give Parties a context for my impression of the existing status of Defendants with respect to that individual provision. I define substantial compliance as a degree of compliance sufficient to not require any oversight or monitoring. I will define non-compliance as being significantly remote from compliance with considerable work needed to attain compliance. Partial compliance will be defined as between non-compliance and substantial compliance with reasonable efforts ongoing to achieve compliance.

EXECUTIVE SUMMARY

Since the new vendor has assumed responsibility for provision of health care, Defendant report have been more straightforward and based on understandable data. This has allowed the program to understand its deficiencies and attempt corrective actions.

There were six items in substantial compliance; 18 items in partial compliance and 14 items in noncompliance.

A major recurring theme is failure of availability of medical record information to providers or nurses in performance of their responsibilities. Interfaces between the laboratory and pharmacy and the electronic medical record are defective. The electronic medical record has no electronic medication administration record which account for several areas of noncompliance or makes it difficult to achieve compliance. Orders for supplies and administration of those supplies can't be tracked on the record and paper audits are currently inadequate. A new medical record is needed.

Intake facilities are inadequate and continue, in my opinion, to contribute to mistakes in intake screening. In several areas, specialized medical housing space is lacking. This would make tracking of diabetic care and tracking of vital signs for persons undergoing detoxification very easy and would facilitate improvement in item 19.g. which is currently in non-compliance.

INTAKE AND INITIATION OF MEDICATION

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

Compliance Rating: Partial Compliance

Findings: For the six month (July, 2019 to December 2019) period related to this reporting period there were 11,015 bookings. In their biennial report, Department of Public Safety and Correctional Services (DPSCS) asserts that an unreliable data feed from the custody database to the electronic medical record makes data unreliable, with data being lost, deleted, or formulated with errors. Apparently, for that reason, DPSCS sampled 390 of the 11,015 (3.5%) bookings and produced the data below as evidence of their performance.

Table 1

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
IMMS s comp eted w th n 2 hours of scan n t me	89%	100%	95%	95%	97%	98%	***97%***
IMMS m grated to the EPHR w th n 4 hours of scan n t me	72%	83%	71%	80%	72%	69%	***75%***
IMMS comp eted by an RN or h gher	100%	100%	100%	100%	100%	100%	***100%***
Score Summary for SA 17A (Accept)	***87%***	***94%***	***89%***	***92%***	***90%***	***89%***	***90%***

These data show that 97% of inmates who are booked have intake screening within two hours of booking. This apparently is data obtained from OCMS the correctional database. Based on this sample, of the 11,015 inmates booked during this time period, approximately 330 inmates did not have intake screening within two hours of booking. The data does not show how many inmates missed intake screening entirely. This would be useful to know because 330 inmates either missed intake screening or had it later than two hours. 330 inmates would be an unacceptable number to have missed intake screening. But would be more acceptable if their intake screening were only delayed.

For this audit sample 162 of the 390 audit sample were persons who were initially rejected at booking and were sent to the hospital for clearance. Of that 162 portion of the sample, the following data were obtained.

Table 2

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
IMMS m grated to EPHR w th n 4 hrs of scan n t me upon return to the fac ty for rejects	39%	80%	87%	69%	73%	60%	***68%***
IMMS s comp eted by an RN or h gher	96%	100%	100%	100%	100%	100%	***99%***
Prov der encounter note n EPHR fo ow ng ER return	83%	64%	88%	80%	95%	100%	***85%***
Score Summary for SA 17A (Reject):	***73%***	***81%***	***92%***	***83%***	***89%***	***87%***	***84%***

The effort to demonstrate compliance is improved but still needs work. The issue in provision 17a is whether nurses complete intake screening within 4 hours of booking. Tables 1 and 2 above do not assess whether this occurs. Table 1, apparently using data from OCMS, identifies that intake screening is completed within 2 hours for 97% of the sample. Instead, this data should include the percent of intake screenings that are completed within 4 hours which is likely to result in a higher percent.

The data shows that transmission of the intake screening (IMMS) into the EPHR is still flawed and deficient which is a significant problem. DPSCS, over several reporting periods, has not been able to eradicate these flaws in data transfers. DPSCS also states it was unable to accurately reconcile electronic data with manual logs. DPSCS is attempting to develop a method to reconcile manual logs and the electronic data they have available. I would encourage expeditious roll out of a satisfactory electronic record that will accurately record these data.

Lastly, for this provisional item DPSCS needs to validate whether the quality of nursing intake screenings are of adequate quality. DPSCS reports on the quality of nurse intake screenings in item 17d & 17e. It should be reported in this provisional item.

For clinical quality of nurse intake screening, a sample of 10 records of a single nurse was evaluated each month. Each month a sample for a unique nurse was used so that over a six month period six separate nurses were evaluated. The samples selected were adequate in my opinion. Record selection was targeted with persons referred to providers based on an urgent need or from those initially rejected at booking who were returning from the hospital. I also agree with this targeted selection criteria.

The data provided in the DPSCS report, shown below in Table 5, shows that there is still opportunity for improvement. I would stress, though, that though these data show need for

improvement, it is very encouraging that such an audit is actually occurring. For this I give the Commissioner and the new vendor much credit.

Table 5

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Intake Screen ng form s comp eted n ts ent rety w th no b anks	78%	95%	90%	73%	70%	83%	***82%***
V ta s gns and peak f ow (resp ratory prob ems) and/or random f nger st ck g ucose (d abet cs) were documented	59%	87%	58%	63%	73%	83%	***71%***
Po nt of Care Test ng s documented on the IMMS n the comments sect on	59%	51%	50%	42%	70%	61%	***56%***
Base ne CIWA or COWS scores are documented on the IMMS for a nd v dua s who reports drug or a coho use	76%	75%	32%	71%	39%	45%	***56%***
The nd v dua was tr aged and referred appropr ated based on the nurs ng assessment and IMMS responses	70%	67%	95%	88%	70%	61%	***75%***
Score Summary for SA 17 Qualitative:	***68%***	***75%***	***65%***	***67%***	***64%***	***66%***	***68%***

It is critical that supervisory nurses, in a collegial manner, give feedback to staff nurses on these results. Also, my first impression in seeing these numbers is to reflect on the conditions of the intake area. The DPSCS report focuses on possible failures of staff to complete their assignments as the cause of these results. However, based on my tours of the intake area lead me to believe that the physical constraints in the intake space and the pressure to move people through the intake process are, in my opinion, a significant contributor to these results. It may be useful to perform a root cause analysis on why these results were obtained. A discussion with staff in intake may help to elucidate whether space or time-pressure conditions contribute to these results. This may not be a problem of lack of staff training and dedication but a cramped, overcrowded, and time-pressured intake area that makes it difficult to impossible for staff to complete their assignments.

Recommendations:

1. Obtain an electronic medical record as soon as possible. Use the electronic record to validate your progress on the timeframe part of this provision.
2. Develop a method to assess quality of intake evaluations as part of your validation of this provision item.
3. Perform a root cause analysis of the intake process to include interviews with intake nurses to establish whether time-pressures or space conditions contribute to the poor quality of care of nursing intake evaluations.

Settlement Agreement Statement: 17.b. *The Commissioner shall ensure that any plaintiff who reports during intake screening that he or she is currently prescribed medication for a medical condition, or who presents with an urgent medical need, shall receive a physical*

assessment by a Clinician within 24 hours of the intake screening, or sooner if clinically indicated

Compliance Rating: Partial Compliance

Findings: It isn't clear in the DPSCS report if data for this item includes an audit of all inmates who are booked or a sample of inmates. The only data verifying this item is in Table 3 below which is from the DPSCS report.Table 3

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There s documentat on on the IMMS of an urgent med ca and/or menta hea th referra	92%	85%	91%	95%	93%	89%	***91%***
There s documentat on of same arrestee's name as an urgent referra on the IMMS Referra Log, same date as IMMS	100%	100%	100%	100%	100%	95%	***91%***
Med ca Prov der encounter for urgent referra comp eted w th n 24 hours of ntake screen ng, or sooner f c n ca y nd cated	90%	92%	91%	98%	96%	96%	***94%***
Score Summary for SA 17B:	***94%***	***92%***	***94%***	***98%***	***96%***	***93%***	***95%***

It is not clear whether documentation on the IMMS of an urgent referral equates to the number who actually need a referral. For example, do all persons with an urgent medical need and all persons on medication get referred for a provider evaluation to occur within 24 hours? This data doesn't show that.

Only 94% of persons referred urgently for evaluation are actually seen by a provider. This number can't be pro-rated to the entire population of booked persons because the number of persons booked who are on medication or in need of urgent evaluation is unknown. Based on my experience, about 50% of persons coming into the jail would have need to see a provider based on the Settlement Agreement language. This would be 5,507 individuals. If 94% of these are seen, then 330 individuals would not have been seen timely. This is about 55 individuals a month who fail to be evaluated for need of a medication or for an urgent need. This is not a good outcome for this provision item.

Lastly, the presentation fails to address the quality of the provider evaluations that were audited.

Recommendations:

1. Include record reviews of provider quality of intake assessments.

Settlement Agreement Statement: 17.c. *The Commissioner shall ensure that any plaintiff who is identified during intake screening as currently prescribed psychotropic medication*

(unless he or she receives a bridge order as provided in paragraph 25.b.) or as having an urgent mental health need, including a suicide risk, shall receive a mental health evaluation by a Mental Health Practitioner within 24 hours of the intake screening, or sooner if clinically indicated.

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

Findings: None

Recommendations: None

Settlement Agreement Statement: 17.d. *To address the needs of plaintiffs who, prior to being taken into custody, were prescribed medication that, if interrupted, would pose a risk of adversely affecting health, the Commissioner shall promulgate and implement policy and procedure to ensure that such plaintiffs receive such medications within 24 hours of the intake screening or subsequent encounter at which the plaintiff first reports such medications to a Medical Professional or Mental Health Professional, or sooner if clinically indicated, unless: (i) a Clinician determines that such continuation is not medically appropriate, including without limitation a determination that continuation is not medically appropriate pending verification of the reported prescription, provided that appropriate verification efforts shall be promptly undertaken; or (ii) despite reasonable efforts consistent with the gravity of the need for the medication, DPDS is unable to timely obtain the medication. The Commissioner shall promulgate and implement policy and procedure requiring reasonable efforts, consistent with the gravity of the need for the medication, to ensure that such plaintiffs are timely provided with the medication or a pharmaceutical equivalent.*

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

Compliance Rating: Noncompliance

Findings: DPSCS has reported 17d & 17e together, so this report will do likewise. A sample population was utilized but the sample size was not provided. Nevertheless, audit results are not good. Data in the DPSCS report is provided below.

Table 4

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There s med cat on order documented for any chron c care or acute med cat ons dent f ed/reported at IMMS or a ternat ve med cat ons ordered	88%	100%	96%	95%	97%	100%	***96%***

There s a MAR generated document ng chron c or acute med cat ons dent f ed dur ng the ntake rece v ng process (IMMS) or a ternat ve med cat ons ordered	77%	32%	52%	51%	79%	77%	***61%***
F rst dose med cat ons reported as IMMS or a ternat ve med cat on ordered were adm n stered w th n 24hs of the IMMS n OCMS	59%	32%	35%	21%	59%	52%	***43%***
There s exp anat on n EPHR for non ordered med cat ons sted 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%***

The data show that only 96% of persons in need of medication had an order for that medication. Typically, about 50% of incoming inmates in a jail will be in need of medication of some sort. If these data are pro-rated to the 11,015 inmates who were booked in this time period about 5,507 inmates will need medication and about 220 individuals over a 6 month period will not have an order for medication.

Evidence for receipt of medication is considerably worse with only 43% of individuals having receipt of medication documented as given in the IMMS. Medication administration records documenting receipt of medication were found in only 61% of individuals who had orders. These data describe significant process issues. In my opinion, some of these issues may be resolved with introduction of an electronic medication administration process. However, even when an electronic medication administration system is put into place, there may be underlying process problems. For this reason, I encourage the DPSCS to continue to attempt to identify those process issues that may be leading to these poor results.

Recommendations:

1. Perform a root cause analysis to determine why medication orders are not resulting in a medication administration record.

MEDICAL PLAN OF CARE

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

Settlement Agreement Statement: 18.b. *For purposes of this Settlement Agreement, an "Ongoing Condition" is a condition that requires ongoing care and that: (i) will not be resolved within a 30-day period; or (ii) constitutes a serious acute injury or illness that will require repeated follow-up (aside from routine medication administration) or has*

lasting significance for the plaintiff's future health care treatment. For those plaintiffs with one or more Ongoing Conditions, a Plan of Care shall be developed by one or more Clinicians, as appropriate, based on physical examination and the documented medical history of the plaintiff, as provided herein.
Settlement Agreement Statement: 18.c. *The Commissioner shall promulgate and implement policy and procedure to ensure that initial diagnosis and identification of Ongoing Conditions, along with any elements of a Plan of Care that do not require development at chronic care clinics or through specialist referral, shall be conducted and entered into the EMR within seven days of the plaintiff's admission, or sooner if clinically indicated.*
Settlement Agreement Statement: 18.d. *During this initial diagnosis and identification process, a Clinician shall order that the plaintiff be enrolled in any chronic care clinics that are clinically indicated and recommend any specialty care that is clinically indicated. Any elements of the Plan of Care developed as a result of enrollment in chronic care clinics or specialty care shall be entered promptly in the EMR.*
Settlement Agreement Statement: 18.e. *If an Ongoing Condition is diagnosed and identified after the initial diagnosis and identification, the Plan of Care shall be promptly updated or created, as appropriate, to reflect such new diagnosis and identification.*
Settlement Agreement Statement: 18.f. *The Plan of Care shall be accessible to any Medical Professional or Mental Health Professional who is providing treatment, including diagnostic services, to a plaintiff, unless the need for emergency treatment precludes access at the plaintiff's location.*

Compliance Rating: Partial Compliance

Findings: DPSCS reported on all provision 18 items in one section. I will report in the same manner. For purposes of verification of item 18, DPSCS utilizes medical record reviews, which I agree with. I have had several calls with DPSCS staff who have been working on developing a methodology for record review. DPSCS has hired Dr. Abebe and Dr. Gibbons as consultants to work on this project. Record reviews are performed by Dr. Abebe and Dr. Tessema, the Medical Director at the jail. The vendor corporate Medical Director, Dr. Ganns, has been fully cooperative with this process.

Record reviews consist of a triggered selection process in which records of medically complex patients are chosen to review. The list is selected from hospital discharge diagnoses based on potentially preventable diagnoses. According to the DPSCS report the reviews, "cover a time span adequate to evaluate the problem being reviewed" thus including intake screening, the first provider assessment, follow up chronic care visits, and intervening nursing assessments. Opportunities for improvement are identified for each episode of care and are coded based on an error type. These are collated and reviewed. The concept is that identified systemic problems area referred to the quality improvement committee to address corrective action by performing root cause analysis.

During the recent reporting time period from July 2019 to December 2019, DPSCS staff have reviewed 19 records. This is approximately three records a month. This should be increased. DPSCS sent me several records that they had reviewed. I reviewed their work and we discussed our common results. In their February CQI meeting, provisional item 18 was discussed including:

- The chart review process
- The intention to review 6 records a month
- A summary of their analysis
- Identification of opportunities for improvement
- A listing of identified problems including:
    - Problems with diagnostic work ups
    - Problems with assessments
    - Problems with appropriate treatment plans
    - Issues with hypertension management

Key findings in record reviews included lapses in formulating a clinical plan that was attributed to either lapse in judgment or clinical knowledge. A second key finding was that there were lapses in execution or delays in care. The formulation of root cause for these clinical deficiencies was not well developed. The DPSCS 6 month report focuses on documentation of providers as a major problem. Likewise, based on corrective actions for record reviews, the deficiencies appeared to be attributed to individual provider performance but did not include systemic issues such as scheduling problems, electronic record deficiencies, information availability on laboratory and medication status, the space and operational problems with the intake area, and support services for chronic illness. Corrective action plans included counseling with providers, disease management training, and improving the standard of care for medication. Poor documentation was attributed to a defective EPHR. The CQI presentation acknowledged that after a corrective action was initiated (e.g. training), the group had yet to develop an evaluation methodology to document improvement.

Identification of systemic issues based on record reviews and audits is still a work in progress. I reviewed the record reviews of the DPSCS auditors. I identified 42 problems that were mostly also identified by the reviewers. My categorization of root causes were somewhat different than DPSCS. Six issues that I repeatedly found included:

1. Use of stat doses of clonidine for minimally elevated blood pressure.
2. Not knowing what medication the patient was on or evaluating whether the patient was receiving their medication.
3. Failure to send the patient to higher level medical housing when indicated.
4. Defects in the EPHR that resulted in lost documents.
5. Failures to identify all medical conditions or medications in intake.
6. A variety of clinical management issues.

Also, eight (20%) of deficiencies were related to intake evaluations by providers. While clinical management issues were evident in items 1 and 6, all other items were reflective of systemic deficiencies that appeared not solely related to provider performance including:

- Item 2 above reflecting inability to have medication records available at clinic visits and inability of the electronic record to accurately reflect what medications the patient was on or to accurately reflect administration of medication.
- Item 3 above which has uncertain cause but appears to reflect a lack of medical protective housing for persons with severe chronic illness.
- Item 4 above which reflects a significantly defective medical record software.
- Item 5 above which identifies defective intake screening which may result from multiple causes.
- 20% of deficiencies were related to intake. Root cause analysis of the intake process is needed. This does not appear to be only a provider problem but appears to represent a problem with the operational issues in intake.

It would be useful to expand root cause analysis of deficiencies to ensure systemic corrective action when indicated. For example, there were 9 observations of a provider missing a problem when developing a therapeutic plan and 16 episodes of inadequate provider identification. In my own observations and in record reviews, I was struck by the lack of an adequate problem list in the electronic record. This can be attributed to a lack of a standardized procedure for entering problems, allowing any staff including nurses to enter problems, and medical record software that mixes nursing and physician diagnoses into the problem lists. These systemic problems contribute to a problem list that is not used because it does not accurately describe a true picture of the patient's problems. While the root cause of missing problems is being attributed to physician performance, in my opinion, a substantial contributor to this problem is the lack of an adequate procedure to enter problems into the problem list and a defective medical record that contains a useless problem list mostly created by nurses who list nursing diagnoses as problems. I would encourage the CQI committee to expand its root cause analysis to include systemic factors into the evaluation. This should involve more probing into why a particular deficiency occurs.

As well as record reviews, DPSCS has initiated compliance audits of records performed by nursing CQI staff to augment record reviews. DPSCS has chosen nine audit questions summarized in Table 6 below as compliance indicators for provision 18 of the Settlement Agreement.

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Do the CC Encounters address the spec f c prob ems dent f ed at the 7 day Intake Exam (exc ud ng those ssue that are reso ved/ nact ve)?	100%	60%	100%	86%	100%	100%	***91%***

Are needs for d sease spec f c ab test mon tor ng eva uated, rev ewed, or ordered?	100%	57%	71%	100%	83%	80%	***82%***
Is comp ance w th chron c med cat ons and or d ets assessed as part of the P an of Care?	100%	0%	80%	83%	60%	75%	***66%***
Is there nd cat on that the chart summary and the hard copy med ca record was rev ewed?	71%	57%	88%	100%	78%	100%	***82%***
Have ep sod c recurrent non ser ous med ca prob ems been assessed w th a p an of care?	67%	100%	100%	100%	100%	100%	***95%***
Do Intake Screen ng encounters ref ect appropr ate CC reg strat on status (w th updat ng or enro ment where app cab e) and schedu ng for CC encounter(s)?	78%	100%	89%	60%	100%	88%	***86%***
Are new y dent f ed CC cond t ons updated to the Prob ems L st?	57%	100%	50%	71%	75%	80%	***72%***
Is the d sease act v ty and contro c ear y nd cated n the P an of Care?	100%	100%	100%	100%	100%	100%	***100%***
Is rev ew of externa spec a ty care and hosp ta or Inf rmary summary /reports and recommendat ons c ear y documented?	40%	50%	67%	67%	71%	60%	***59%***
Score Summary for SA 18:	***79%***	***69%***	***83%***	***85%***	***85%***	***87%***	***81%***

These audit questions are performed by nurses. I have expressed concern to DPSCS whether nurses can evaluate some of these questions. For example, can a nurse determine if a physician ordered appropriate tests, whether the physician evaluated all medical conditions, or whether disease activity is appropriately assessed? A compliance audit would be a useful contribution to verification of item 18 but, in my opinion, I would modify the audit questions. Instead of asking whether disease specific lab testing was ordered I would ask whether physician-ordered laboratory tests, imaging studies, and other testing were completed timely as ordered and whether the lab review process works as designed. Instead of asking whether compliance with medications were assessed, I would ask whether the patient received ordered medication and whether ordered and administered medication information is available to the provider at each clinic visit. Instead of asking whether a physician adequately assessed problems, I would ask whether all scheduled provider appointments occurred as scheduled. Instead of asking whether a physician appropriately reviewed hospital and specialty consultant reports and recommendations, I would ask whether the provider specialty referrals occurred as ordered. Most of the questions on the nursing audits are questions that need to be addressed in record reviews because they require a physician judgment. The audit questions need to focus on compliance issues that do not require a physician judgment yet answer questions about support structures for the chronic care program.

Recommendations:

1. Perform a greater number of record reviews than are now currently being done.
2. Include root cause analyses of systemic issues identified from record reviews which should be part of quality improvement activity.

3. Ensure that the new electronic medical record has ability to create a problem list and has electronic medication administration documentation capability so that it is accessible to practicing providers.

MEDICATION MANAGEMENT AND TESTING

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

Compliance Rating: Non-compliance

Findings: To verify this provision, DPSCS has structured an audit to determine if a patient is regularly seen in chronic clinic and whether those visits translated in orders for medications which demonstrate uninterrupted medication administration as evidenced on medication administration records.

This audit could be automatically produced for 100% of patients if a reasonable electronic medication administration record were available. Since the electronic record is still unavailable, this audit was constructed. The sample size was not given in the DPSCS report; this should be provided. This audit is a significant effort. The vendor CQI team was largely responsible for this study and I give them much credit. Their data, as provided in the DPSCS report is provided in Table 7 below.

Table 7

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Comp ance w th chron c care po cy as shown by order n EPHR for th s pat ent to be seen n Chron c Care C n c for h s/her prev ous y d agnosed chron c hea th cond t on	82%	74%	92%	55%	92%	97%	***82%***
Comp ance w th chron c care po cy for the f rst appo ntment w th n 30 days or as c n ca y ordered as shown by EPHR rev ew ca cu ated as t me between order date and chron c care appo ntment	77%	57%	71%	41%	62%	74%	***64%***
Ongo ng comp ance w th chron c care c n cs w th n 90 days or as c n ca y ordered shown by EPHR rev ew ca cu ated as t me between the ast chron c care encounters	67%	38%	60%	16%	33%	55%	***45%***
Chron c med cat ons ordered for 120 days as shown by the start and stop dates on the order n EPHR	66%	42%	66%	34%	60%	65%	***56%***
Start and stop dates accurate y transcr bed on MARs	43%	40%	44%	25%	49%	62%	***44%***

A rev ew of the MAR shows cont nu ty of med cat ons w thout nterrupt on	41%	32%	90%	60%	74%	82%	***63%***
Score Summary for SA 19A:	***63%***	***47%***	***71%***	***39%***	***62%***	***72%***	***60%***

These data do not reflect a good system. DPSCS attributes these medication related problems to excessive provider appointments with failure to consistently monitor medications and failures of physicians to prescribe medications for a duration conforming to chronic clinic intervals. Based on my own record reviews and these data, the major problem in this area is not physician centered. A medication support system must be able to provide accurate medication lists, accurate administration rates, a stop order system that notifies physicians when medications are expiring, a reasonably efficient and time-saving way to safely renew medications, and an electronic record or paper system that provides information related to medication ordering, administration and compliance. The root cause of failure of continuity of medications does not, in my opinion, reflect a problem with physicians. The root cause of this failure resides in failure of the pharmacy to integrate with the electronic record and failure of this system to provide physicians information about medication ordering, medication expiration, medication administration, and medication compliance which is critical for their ability to care for patients.

Recommendations:

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

Compliance Rating: Non-compliance

Findings: This item also is one that should be able to be performed automatically for 100% of patients *if* an electronic medication administration record were available. Lacking such a system, the Corizon CQI team performed a paper audit of medication administration records. The sample size and methodology were not provided. Their data is provided below in Table 8.

Table 8

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Med cat on adm n stered by LPN or h gher (conf rmed by s gnature and censure documented on the back of the MAR LPN, RN, PA, NP)	11%	12%	46%	20%	38%	46%	***29%***
Med cat ons adm n stered as ordered (no ho es/b anks) "N" for any ho e or b ank	83%	35%	92%	55%	57%	85%	***68%***

M ssed med cat on documented us ng approved codes	71%	52%	61%	30%	51%	63%	***55%***
Number of b anks or ho es n the MAR (number of m ssed doses w th no exp anat on)	127	173	6	38	103	26	***79***
Leg b e name of nurses adm n ster ng med cat ons whose n t a s appeared on the MAR w th app cab e profess ona censure 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%***

The DPSCS report identifies the two biggest problems identified as:

1. Inability to locate paper medication administration records. This implied that either a medication record was not initiated or it was lost.
2. Failure to document administration of medication on a medication administration record.

One comment on this audit is that there were significant numbers of blanks on the medication records (audit question 4) but this numerator needs a denominator. How often are there missed doses without explanation?

Based on the opportunities for improvement section of this provision, it appears that DPSCS attributes these poor results to accountability of nursing staff in documentation of medication administration. Similar to attributing difficulties on provision 18 to physician performance and documentation, difficulties on item 19.b. are attributed to performance issues with nurses.

My own observations is different. For example, I have found on record reviews that patient movement is considerable and when patients move, the medication administration record and the medication do not move with the patient and nursing staff is unable to identify that a patient is on medication. As a result, these patients may miss their medication, sometimes for extended periods of time. The knowledge that a patient in a new location is on medication and the availability of that patient's paper medication records is a significant problem. When a patient moves to a new location, the pharmacy is unaware of where the new location is and multiple nurses have told me that medications are often sent by pharmacy to the wrong location causing missed medication. How can nurses reliably be expected to perform when the process of managing medication is defective? There are multiple areas of medication administration that must be considered in the root cause analysis with respect to this item. They include:

- Pharmacy issues with respect to delivery of medication to the right location.
- Pharmacy issues with respect to accuracy of the medication administration record.
- Ensuring that nurses have an accurate and reliable medication administration record in the location where the patient is housed.

- Improvement of the electronic record to include an electronic medication administration record that simplifies documentation and accuracy of medication administration.

Recommendations:

1. Obtain a new electronic medical record with electronic medication administration record capacity.
2. Perform a root cause analysis as to why patient movement results in missing medication.

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

Compliance Rating: Non-compliance

Findings: This provision was verified by an audit. The sample size of the audit should be included. This is a straightforward audit that examines a sample drawn from patients who had orders in the EPHR for blood glucose testing or vital sign testing. The results of the audit are provided in Table 9 below.

Table 9

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
V ta s gns comp eted and documented as ordered n EPHR	8%	4%	18%	7%	8%	0%	***8%***
B ood sugar tests comp eted and documented n EPHR as ordered	100%	13%	0%	0%	0%	29%	***24%***
V ta s gns resu ts documented as rev ewed by c n c an dur ng pat ent encounter	6%	8%	10%	20%	5%	11%	***10%***
B ood sugar tests documented as rev ewed by c n c an dur ng pat ent encounter	n/a	86%	75%	n/a	17%	86%	***66%***
Score Summary for SA 19C:	***38%***	***27%***	***26%***	***9%***	***7%***	***31%***	***23%***

The DPSCS discussion of these results in the opportunities for improvement section implies that the electronic record ordering template may be producing inaccurate reports regarding orders and may be resulting in physician orders that are not performed because staff don't know there is an order. If this is an accurate description of the process it is dangerous.

Also, DPSCS discusses that documentation of results of these orders is inconsistent mostly because the manner of documenting review of these results by providers does not result in clear documentation in the EPHR that a review has occurred. This implies that DPSCS does not know if providers are not reviewing lab and vital sign results or if malfunctions

in the EPHR are making it appear that providers are not reviewing these results. The corrective action DPSCS recommends for this problem is to create a performance expectation of where physicians should be documenting their review. This unfortunately should be something the EPHR should perform automatically.

Recommendations:

1. Obtain a new electronic medical record and reassess.

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

Compliance Rating: Non-compliance

Findings: DPSCS verifies this provision with two audits. One audit consists of evaluating a sample of patients who have keep-on-person (KOP) medication ordered, submitted a sick call slip for a medication refill, and appear on a 30-day medication expiration report. The summary of these audit findings is in Table 10 below.

Table 10

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
KOP med cat on rece pt by pat ent documented on MAR for each KOP ref request for the most recent s ck ca request for rev ew	40%	42%	14%	9%	0%	17%	***20%***
No apse n med cat on between dates ref s were rece ved by pat ent measured as the number of doses from ast f to the current f	45%	38%	50%	14%	61%	86%	***49%***
Score Summary for SA 19D:	***43%***	***40%***	***32%***	***12%***	***31%***	***51%***	***35%***

A second audit addresses the last phrase in this provision which requires a process for expedited refills of KOP medications for potentially urgent needs. The results of these data is provided in Table 11 below. This audit does not verify that inmates in need of an urgent refill of a KOP but only that the medication is kept on stock. For that reason this audit does not satisfy the Settlement Agreement requirements.

Table 11

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Stock med cat on supp y (presence of med cat on)	No data	No data	95%	90%	94%	96%	***94%***

Based on the discussion in the opportunities for improvement section, it appears that auditors could not determine in the EPHR whether medication was directly observed therapy (DOT) or KOP. The analysis also asserted that nurses should use a KOP stamp on the medication administration record to designate whether the patient was to receive KOP or DOT. In functional medication systems, the pharmacy produces medication administration records as needed that indicate whether medication is to be DOT or KOP. That DPSCS expects nurses to reconcile medication records and ensure they are accurate is a pharmacy and medication management failure.

Recommendations:

1. Obtain a new electronic medical record and reassess.

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

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

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

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

Compliance Rating: Non-compliance

Findings: DPSCS combined 19.e and 19.f and this report will do the same. To verify compliance with this item an audit was performed to test whether the lab log was completed, that the test was completed within the timeframe requested, that stat labs were completed within four hours, that critically abnormal results resulted in provider

notification within 15 minutes, that there was evidence of review of labs within two days, that the patient was notified of results and that a hard copy of the results were found in the EPHR within two days.

These results were said to include tests for Methicillin-Resistant Staphylococcus aureus (MRSA) but the number of these tests was not specified. The number of MRSA tests should be included. It is not clear why the audit included whether a hard copy of the lab is uploaded to the EPHR within 2 days. Typically, laboratories interface with electronic records and all test results are uploaded to the electronic record within minutes of being completed by the lab. If this is not done, it is a serious problem with the electronic record. If this interface exists, why include this question?

This audit is a reasonable methodology to measure compliance with this Settlement Agreement provision. Audit results are shown below in Table 11.

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
Lab requests are sted on the fac ty Lab Log? (Date of order, Date test drawn/comp eted, Date resu ts rece ved, Date resu ts rev ewed by prov der, Date resu ts shared w th pat ents, and Date rev ew was documented n hea th record)?	0%	0%	0%	0%	0%	0%	*0%*
There s ev dence that the ab test was comp eted w th n the t meframe spec f ed n the prov der s orders?	13%	67%	91%	77%	46%	48%	*57%*
Stat abs resu ts were rece ved w th n (4) hours of the draw by a nurse or h gher? (except on for tests that cannot be comp eted w th n t meframe, e.g. cu tures)	n/a	n/a	n/a	n/a	n/a	0%	*0%*
If critical / abnormal results were noted, the provider was not f ed of the ab resu ts? (Cr t ca = Immed ate y (w th n 15 m nutes of rece pt), Abnorma = w th n same day rece ved or w th n (4) hours)	7%	50%	30%	67%	27%	60%	*40%*
There s ev dence that the ab resu t was Rev ewed, S gned, and Dated by prov der w th n 48 hours after rece pt of test resu ts?	13%	75%	60%	55%	46%	42%	*49%*
There s ev dence that rev ewed abs have wr tten prov der fo ow up on ab va ues or test resu ts? (w th n 24 hours of rece pt for cr t ca and abnorma resu ts, 48 hours of rece pt for norma resu ts)	10%	100%	60%	33%	38%	32%	*46%*
There s documentat on the pat ent was not f ed of norma /abnorma ab resu ts? (Rout ne= 7 bus ness days, Abnorma = 24 hours of rece pt of resu ts).	9%	50%	22%	25%	0%	21%	*21%*
The hard copy ab test resu t was up oaded nto EPHR w th n 48 hours of the prov der's date and s gnature?	0%	0%	0%	0%	46%	53%	*17%*
Score Summary for SA 19E and SA 19F:	***10%***	***68%***	***53%***	***51%***	***40%***	***41%***	***44%***

These results are not good. Any facility I have ever monitored that has an electronic medical record has never had a problem with timely referring laboratory results to physicians or having physicians review those results. DPSCS, in the opportunities for improvement section, describes problems with the bi-directional interface between the laboratory vendor and the EPHR. The poor results are attributed to interface issues with the lab and EPHR. However, in my experience, even when a correctional facility utilizes a paper record, these results would be considered extremely poor results. If the electronic record will be delayed, DPSCS must develop a reliable, timely, and safe system of

returning of laboratory results to physicians and ensuring their timely entry into the medical record.

Recommendations:

1. Fix the bidirectional interface between the laboratory and the electronic medical record.

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

Compliance Rating: Non-compliance

Findings: DPSCS verifies this provision using an audit that has pertinent questions. The sample size is not described in the DPSCS report. The results of this audit are shown below in Table 12.

Table 12

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There s an order for b ood sugar or v ta s gns mon tor ng n EPHR by the prov der w th parameters n the aud t per od	26%	17%	34%	10%	6%	12%	***18%***
There s documentat on n the EPHR that the v ta s gns and /or b ood sugars were taken accord ng to the prov der orders dur ng the aud t per od	12%	13%	2%	2%	3%	2%	***7%***
Abnorma resu ts for v ta s gns and /or b ood sugar have documentat on n EPHR w th nurs ng referra to the c n c an dur ng the aud t per od	24%	22%	35%	83%	0%	13%	***30%***
There s documentat on of the rev ew and d spos t on by the c n c an n EPHR for abnorma read ngs of v ta s gns or accucheck as a resu t of that nurs ng referra dur ng the aud t per od	13%	14%	24%	50%	0%	0%	***17%***
B ood sugar tests reported n the ab contractor b ood sugar report documented as rev ewed n EPHR by c n c an dur ng pat ent encounter dur ng the aud t per od	23%	21%	76%	50%	100%	40%	***52%***
There s abnorma A1C >9 resu t for the aud t per od dur ng the aud t per od	45%	7%	60%	100%	0%	100%	***52%***
Score Summary for SA 19G:	***24%***	***15%***	***39%***	***49%***	***18%***	***28%***	***29%***

That only 17% of abnormal results are documented as reviewed by a physician is a very poor result. This is not unexpected insofar as only 30% of abnormal results have evidence of a nurse referral to a physician. In this regard approximately 56% of abnormal tests actually referred by nurses are documented as reviewed.

I would note that the audit does not describe the degree of abnormality which is considered reportable; this should be done. The level of abnormality should be standardized and defined in policy not arbitrarily determined. The auditors for DPSCS assert that each individual physician order should describe parameters for when notification is to occur and that individual nurse judgement, in the absence of provider instructions, should determine when notification is made. This would be extremely cumbersome and practically is never done in my experience. Levels of CBG that require notification are typically standardized and described in policy and DPSCS should do the same. If DPSCS uses nurse judgment as a criteria for when an abnormal test needs to be reported, it would be impossible to audit because each nurse may conceivably use a separate personal standard as a threshold for reporting.

In their discussion of these results, DPSCS asserts that process issues with an ordering template in the EPHR contribute to these poor results. The DPSCS corrective action is to create a system of accountability of providers in ordering these tests. This, in my opinion, is not an accountability problem of providers but a system design issue with how abnormal test results are addressed. DPSCS needs to establish standardized thresholds for which a nurse needs to notify a physician. In many systems, when such a threshold is reached, a nurse obtaining the abnormal value calls a physician on call and asks for guidance. The nurse documents that conversation with any orders or directions in the medical record. DPSCS should review this process and determine if there is a more efficient procedure.

Recommendations:

1. Standardize reportable laboratory results.
2. Fix medical record issues so that reportable results are queued to the responsible physician.

INTERACTION BETWEEN MEDICAL AND CUSTODY

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

Compliance Rating: Non-compliance

Findings: An audit was performed using a sample population of patients scheduled for on-site and off-site specialty or diagnostic care and emergency room care. The audit asks five questions. The data for this provision is given in Table 13 below.

Table 13

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	Totals
There s a med ca order for the test, consu tat on serv ce or ER v s t	100%	98%	88%	100%	88%	94%	**95%**
There s documentat on of the comp eted consu tat on or med ca test n EPHR w th c n c an s rev ew and d spos t on	50%	52%	36%	48%	41%	26%	**42%**
There s documentat on n EPHR of rev ew of the ER report by the c n c an fo ow ng return of the deta nee to the fac ty	0%	50%	100%	67%	100%	100%	**70%**
If there was a m ssed appo ntment, there was a documented reason for the m ssed appo ntment n EPHR	7%	11%	24%	33%	0%	38%	**19%**
If there was a m ssed appo ntment, there s documentat on of reschedu ed and comp eted appo ntment n EPHR	23%	0%	0%	0%	0%	50%	**12%**
Score Summary for SA 20A:	***36%***	***42%***	***50%***	***50%***	***46%***	***62%***	***48%***

These data show poor results, especially for information about missed appointments. However, the data do not address the central question of this provision which is whether internal scheduled appointments and off-site scheduled appointments occur as scheduled. I have been told during multiple site visits that custody leadership maintains a tracking log of all scheduled appointments, both on-site and off-site appointments. I was told that all appointments are tracked including I have recommended previously that this tracking data be summarized in a spreadsheet and presented as data for this item. This tracking data should separate internal onsite appointments and external offsite appointments. The information maintained on the tracking logs needs to include the referral or order date; the appointment date; whether the patient was seen or not; if not seen the reason for the no-show; a rescheduled date for appointments not kept; and whether the rescheduled appointment takes place; and if not then why the patient was a no-show. This should be repeated until a completed appointment occurs.

The data that was provided does not inform how many offsite appointments actually are seen. However, when there is a missed appointment there is no evidence in the record that the patient missed the appointment and was rescheduled. The opportunities for improvement section mentions that lack of custody personnel to transport patients for scheduled offsite appointments was noted throughout the study period. A table demonstrating the data from tracking logs indicated in the paragraph above would quantify this problem.

I note that the August 2019 Interagency Agreement between Pre-trial Detention and Services and Corizon includes in item number 14 a requirement to maintain a tracking log.

If a referral date would be added to this information it could be used for purpose of verifying the sick call portion of this item.

Recommendations:

1. Maintain a tracking log of appointments to include:
   a. Referral date,
   b. Appointment date of referral or scheduled onsite activity,
   c. Whether the patient shows up and is seen for the appointment, and
   d. If the patient doesn't show up why the patient didn't show up.

Settlement Agreement Statement: 20.b. *The Commissioner shall promulgate and implement policy and procedure to ensure that when Medical Professionals or Mental Health Professionals direct medical accommodations (such as bottom bunk placement, access to a cane or crutches, specialized housing for medical or mental health purposes, or for purposes of protection from exposure to excessive heat), custody staff follow such directives. In the event that custody staff have concerns about the security implications of a particular medical accommodation, a mechanism shall exist to resolve such concerns promptly in a manner that does not threaten the health or safety of the plaintiff whose accommodation is at issue.*

Compliance Rating: Non-compliance

Findings: This provision was audited using a sample population of persons who had orders for a specific accommodation. Data for this provision is shown in Table 14 below.

Table 14

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There s an order n EPHR for cane, crutches, whee cha r, bottom bunk, and any other d sab ty (v sua mpa rment, se zure, orthoped c restr ct ons, hear ng mpa rment)	44%	68%	63%	63%	63%	85%	***64%***
There s a copy of a comp eted transfer of hous ng form n the med ca record	100%	95%	93%	100%	100%	100%	***98%***
There s a s gned rece pt of durab e med ca equ pment n the med ca record for each deta nee	55%	55%	61%	83%	100%	54%	***68%***
Deta nees are housed n the des gnated areas for ADA hous ng (conf rmed dur ng jo nt custody/med ca ADA rounds for pat ents that requ re ADA accommodat ons, and on the Inmate Traff c H story n OCMS for pat ents that requ red bottom bunk who d d not requ re an ADA accommodat on)	81%	74%	70%	59%	59%	60%	***67%***
Score Summary for SA 20B:	***70%***	***73%***	***72%***	***76%***	***80%***	***75%***	***74%***

The data show that in the sample studied, only 64% of individuals had an order in the EPHR for the accommodation. What is unclear is how was it determined that an accommodation was necessary if there was no order in the EPHR? The DPSCS report states that DPSCS does not have a comprehensive listing of patients who are ordered a low

bunk. Obtaining information on orders for accommodations was not able to be obtained from the custody database or the EPHR. This may be able to be resolved with an improved electronic record.

Recommendations:

1. Fix the order system in the electronic record so that orders for accommodation can be obtained. Also arrange that deliver of the ordered accommodation to the inmate is tracked in the electronic record so that this data is obtainable in an audit.

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

Compliance Rating: Substantial Compliance

Findings: This provision was verified at my last visit. Paper lists of all inmates with their current housing data were available in health care areas. DPSCS was in process of training all staff to have access to the custody database (OCMS) so that they could look up a current location. I questioned multiple staff who were able to demonstrate how to do this.

Recommendations:

1. None

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

Compliance Rating: Patial Compliance

Findings: On August 27, 2019 DPSCS emailed me two interagency agreements. Both were agreements between Corizon and Division of Pre-trial Detention. One was an agreement regarding medication management and the second was an agreement regarding sick call. Both agreements were adequate.

Data to verify this provision with respect to sick call is provided with provision 23. b, c, and d. However, I would ask that verification of the implementation of the medication administration policy would include observation of medication administration. Verification of sick call procedures would include evaluation of sick call tracking logs showing substantial show rates for onsite clinics.

Recommendations:

1. Verify that the interagency agreement procedures are being followed.

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

Compliance Rating: Substantial Compliance

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

Recommendations:

1. None

Settlement Agreement Statement: 20.f. *In the event that the temperature control system of a housing unit used for H1 plaintiffs fails to maintain the temperature below 88˚ Fahrenheit, the Commissioner shall, to the extent possible and safe, transfer such H1 plaintiffs to other H1 housing. If insufficient H1 housing is available, appropriate Clinicians shall determine which HI plaintiffs are priorities for transfer to the available H1 housing. Respite in air-conditioned areas shall be provided for such plaintiffs, as well as other plaintiffs as required pursuant to Maryland Division of Pretrial Services, Directive 185.008 (2009).*

Compliance Rating: Substantial Compliance

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

Recommendations:

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

Compliance Rating: Substantial Compliance

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

Recommendations:

ACCOMMODATION FOR PLAINTIFFS WITH DISABILITIES

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

Compliance Rating: Non Compliance

Findings: DPSCS verifies this provision with an audit. The sample size is not provided. The audit traces whether there is an order for supplies and whether the patient received the ordered supplies. Data for this audit is provided in Table 15 below.

Table 15

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There s an order n EPHR for the spec f c med ca supp es (for examp e co ostomy bags, ur nary catheter, etc.) for each deta nee deta ng the type and quantity	86%	67%	88%	40%	71%	88%	***73%***
There s a copy of the comp eted d sab ty assessment form n the med ca record.	100%	89%	100%	100%	71%	100%	***93%***
There s a copy of s gned rece pt for med ca supp es that s cons stent w th order for the deta nee (type and quantity)	86%	100%	100%	100%	43%	93%	***87%***
In t a med ca supp es were prov ded w th n 12 to 24 hours of the order (t me ness of n t at on of order)	64%	44%	33%	60%	0%	64%	***44%***
Subsequent supp es were prov ded cons stent w th the estab shed protoco	67%	50%	83%	60%	0%	50%	***52%***
There s a copy of a comp eted transfer of hous ng form n the med ca record	100%	100%	100%	100%	100%	94%	***99%***
Deta nees sted on the ADA og are housed n the des gnated areas for ADA hous ng (conf rmed dur ng o nt custody/med ca ADA rounds)	71%	78%	88%	50%	86%	69%	***74%***
Score Summary for SA 21A:	***82%***	***75%***	***85%***	***73%***	***53%***	***80%***	***75%***

These data show that inmates are receiving supplies only 50% of the time which is not good. This data should be able to be obtained from the electronic record but the existing EPHR is unable to provide this information. Regardless, 100% of patients were included

in the sample. DPSCS acknowledges that ADA needs are not consistently identified at intake. This failure should be included in the quality evaluation of intake assessments by providers in item 18. Documentation of receipt of medical supplies was frequently unable to be located in the EPHR. These are paper documents which are not timely filed into the paper medical record. This is another instance in which paper documents are used because of a defective medical record.

Recommendations:

1. Fix the electronic record so it can document receipt of ordered supplies or develop a paper system that tracks this information based on orders in the electronic medical record.

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

Compliance Rating: Substantial Compliance

Findings: A custody officer has been assigned as the ADA officer. This officer has training and experience as a nurse aide who worked as a home health staff person who cared for persons with disabilities. This officer tracks non-clinical issues for every patient who is housed on one of the disability units. Non-clinical issues are unrelated to nursing care but are necessary for accommodation of the patient's needs. This person maintains a log of her work. I examined the log which verifies consistent tracking of issues for disabled inmates.

The vendor also has a RN assigned to track disabled patients. The nurse tracks only clinical issues.

Recommendations:

1. None

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

Compliance Rating: Non Compliance

Findings: 100% of ADA patient appointments were audited. Findings are found below in Table 16 below.

Table 16

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
There s documentat on of encounter n EPHR for each deta nee schedu ed for a c n c appo ntment	65%	76%	85%	80%	82%	100%	***81%***
There s documentat on of encounter n EPHR for a reschedu ed appo ntments	38%	14%	25%	0%	20%	100%	***33%***
Score Summary for SA 21C:	***51%***	***45%***	***55%***	***40%***	***51%***	***100%***	***57%***

This data shows that 19% of scheduled appointments for disabled patients didn't occur and that for those that don't occur only 33% are rescheduled. This is not good. In their report DPSCS states that offsite and onsite specialty appointments are particularly problematic without explanation.

In addition, access to care for a disabled patient includes having an appropriate examination table that accommodates disabled persons. The facility does not have proper table yet.

Recommendations:

1. Perform a root cause analysis regarding why ADA patients fail to show for appointments and only a third are rescheduled.

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

Compliance Rating: Substantial Compliance

Findings: The Department has an adequate policy describing use of vehicles for the disabled. There are two vehicles with adaptations suitable for disabled inmates. Each has a ramp allowing for entry of a person in a wheelchair. A wheelchair can be safely secured in the van. Or, the patient can be secured in a seat. In all situations, patients are secured with a seat belt. I have previously observed an officer wheel a mock patient into the van and secure the patient. This vehicle appeared adequate.

Recommendations:

1. None

SPECIALTY CARE/CONSULTATION

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

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

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

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

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

Compliance Rating: Partial compliance

Findings: Provisions 22. a, b, c, d, and e, are combined in the DPSCS report. Provision 22.b requires that patient are referred as medically necessary yet this statement was not evaluated in the data provided. My suggestion is to evaluate this item with record reviews using chronic conditions that typically call for specialty referral as a trigger for chart selection. Provision 22.c requires that a log be maintained that documents all referrals which wasn't included in this report. If this log is electronic it should be submitted as an Excel spreadsheet appendix on the thumb drive containing the report. If this log is a paper log, it should be scanned and sent as a PDF attachment. My preference is an electronic log. Provision 22.d is not addressed in the data presented.

For purpose of verification an audit was provided. The sample of cases was based on offsite, onsite, and emergency room visits. Onsite specialty care should be tracked with other onsite appointments as described in 20.d. "ER visits" are not all emergency specialty

visits so sample selection should be modified accordingly. The data for this audit was obtained from the Corizon company specialty care database. The report asserts that a manual log is maintained at the jail and that regular "reconciliation" occurs to ensure that requests on the log have been processed. The data for this provision should be obtained from the onsite log not the company log. Also, the sample used for this audit did not include denials of care. All referrals for care need to be included in the log tracking specialty care. If specialty care is denied, the denial needs to be noted and any alternate treatment plans need to be documented in the log as well as in the medical record. It is also not clear how referrals are documented. Referrals should be based on orders related to a plan of care that can be verified in the medical record. The data obtained for verification of this item is given in Table 17 below.

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
The Consu tat on Request form s comp eted n ts ent rety, w th no m ss ng pert nent nformat on; at a m n mum the fo ow ng f e ds need comp eted on the Chm_consu tat on temp ate n EPHR: Se ect off s te, ons te c n c, or te emed c ne. Se ect urgent, rout ne, or Retro Request. Spec a ty Serv ce Requested, Prov der, In t a V s t or F/U, and S te Med ca Prov der?	26%	31%	43%	38%	38%	41%	**36%**
The referra processed n a t me y manner? (.e. rout ne referra 5 bus ness days; urgent referra 1 2 bus ness days; emergent referra same day; and documented n EPHR)	97%	96%	93%	90%	93%	95%	**94%**
There s ev dence n the UM Log that the off s te appo ntment was schedu ed t me y after the author zat on number was prov ded to the s te (dec s on date on UM Log). Spec a ty consu tat on w th n 60 days of the author zat on or w th n 90 120 days for ess ava ab e spec a t es).	90%	93%	96%	96%	92%	97%	**94%**
If an ATP was rece ved and accepted by the prov der, were the ATP recommendat ons noted and fo owed up by the prov der w th n 48 hours?	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
The s te prov der rev ew the Consu tat on Report/C n ca Summary, prov de fo ow up care and document n EPHR w th n 48 hours	60%	63%	76%	70%	69%	74%	**69%**
The consu tat on report, ER d scharge nstruct ons, or hosp ta d scharge report were s gned and dated by the rev ew ng prov der and up oaded nto EPHR w th n 48 hours of the rev ew date.	12%	25%	34%	15%	31%	48%	**28%**
Score Summary for SA 22:	***57%***	***62%***	***68%***	***62%***	***65%***	***71%***	***64%***

Some questions arise based on data in this table. If forms are completely filled out only 36% of the time, how is it clear that the urgency of the appointment is known? If the urgency request is not known, how can one be sure that the referral occurred timely? This should be clarified when presenting this data. Also unless the log is present it may not be possible to determine whether the timeliness of the referral was appropriate. This will be difficult for a nurse to determine as this is mostly a physician judgment.

Recommendations:

1. Standardize tracking of offsite specialty logs. The log used should be the onsite DPSCS log and not the company log.
2. Denials of care need to be included on the log. All referrals should be on the log with their disposition.

SICK CALL

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

Compliance Rating: Partial Compliance

Findings: This provision needs to consist of a tour to identify that every housing unit has a secure sick call box into which inmates can confidentially place a health request. This presumes that every housing unit has sick call slips available. There needs to be evidence that health care staff pick up slips on a daily basis. The report merely asserts that there is a locked box on every housing unit. There is no assessment regarding availability of health requests. There is no data with respect to picking up health requests daily.

Monthly rounds on the housing units can be a method of verifying that all housing units have a sick call box and health requests. A method to verify this is having a paper log in the sick call box on which the person picking up slips documents, dates, and initials how many slips were picked up that day. These slips can be tallied monthly and these tallies can be used to verify this provision.

Recommendations:

1. Track pick up of sick call slips on a daily basis and provide monthly aggregate report to the quality improvement committee.

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

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

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

Compliance Rating: Partial Compliance

Findings: Provisions 23. b, c, and d are combined in the DPSCS report. An audit was performed using a sample of sick call slips for symptomatic medical complaints. The sample size was not provided. The data of this audit is provided below in Table 18.

Table 18

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	Totals
S ck ca s p was stamped w th date and t me rece ved	65%	85%	85%	85%	73%	87%	***80%***
S ck ca s p was stamped w th date and t me of tr age	63%	77%	82%	80%	77%	82%	***77%***
The s ck ca s p was tr aged by an RN or h gher	52%	82%	87%	72%	77%	87%	***76%***
There s documentat on of s ck ca encounter correspond ng to the s ck ca s p comp a nt dated for the aud t per od	59%	78%	93%	95%	97%	88%	***85%***
S ck ca encounter occurred w th n 48 hours to 72 hours (f on a weekend or ho day)	50%	50%	81%	90%	93%	79%	***74%***
If s ck ca appo ntment was m ssed, there s documentat on of reason for m ssed appo ntment nEPHR	7%	29%	56%	57%	100%	40%	***48%***
There s documentat on of an encounter n EPHR demonstrat ng comp et on of the re schedu ed/m ssed s ck ca appo ntment	15%	33%	33%	50%	40%	73%	***41%***
There s documentat on w th n the encounter that dent f es a phys ca assessment and p an that addressed the spec f c s ck ca s p comp a nt	37%	67%	67%	76%	8 %	82%	***68%***
There s a d spos t on spec f c to the comp a nt dent f ed on the s ck ca s p 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%***

These data show that almost every audit indicator needs improvement. Typically, in correctional facilities, a log of health requests is maintained to include the date of request, the date of triage, the reason for the request, the date of the face-to-face nursing visit when indicated, and the date of referral to provider when indicated. Rescheduled appointments should be included. This type of log should be used in BCBIC. All data should be summarized in a table month to month and sent to the QI committee. It is best if this can be maintained electronically on a spreadsheet. This data can be used for verification of this item.

This provision also requires that sick call evaluations are of adequate quality. For this purpose, every week 10 patient records for patients evaluated in sick call are audited. This audit is appropriate for this purpose with one exception. I ask that the nursing note

documents an appropriate history for the complaint. The data for this audit is listed in Table 19 below.

Table 19

Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
The correct OTC protoco has been se ected for the comp a nt descr bed on the s ck ca request	83%	100%	91%	88%	100%	96%	***94%***
App cab e v ta s gns (pu se ox, FSBG, PEFR), nc ud ng a we ght, are documented w th act on taken for abnorma f nd ngs (nc ud ng prov der not f cat on)	57%	88%	84%	90%	94%	88%	***84%***
The nurs ng s ck ca encounter s documented n SOAP format	83%	40%	38%	38%	58%	74%	***55%***
Pat ent s referred appropr ate y to the next eve prov der, when nd cated	90%	92%	94%	88%	89%	91%	***91%***
Pat ent educat on s documented	30%	45%	37%	30%	46%	45%	***39%***
Phone or verba consu tat on w th a prov der s documented, as app cab e	n/a	100%	100%	0%	n/a	n/a	***67%***
Score Summary for SA 23 (Quality):	***69%***	***78%***	***74%***	***56%***	***77%***	***80%***	***72%***

I would include in this process feedback to the nurse who is being audited. I would also maintain data on individual nurses and whether there is improvement audit to audit. I note that selection of the correct OTC protocol does not ensure that the nurse takes an adequate history of the patient's complaint. Therefore some assessment of the nurse history needs to occur.

Recommendations:

1. Perform root cause analysis as to why these results occurred and attempt corrective action.

MEDICAL RECORDS

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

Compliance Rating: Non Compliance

Findings: A sample of patient scheduled for a variety of clinics was audited to ensure that a paper record was available to the clinician when the patient was seen and that the clinician seeing the patient documented that the record was available and reviewed.

Data for this item is presented in Table 20 below.

Table 20

	Audit Indicator	Jul	Aug	Sept	Oct	Nov	Dec	*Totals*
SA 24	There s a check mark aga nst the name of the pat ents on the c n c schedu e nd cat ng the hard copy hea th record was pu ed for a pat ents schedu ed for that c n c	90%	90%	55%	69%	88%	73%	***78%***
	There s documentat on of the encounter n the EPHR not ng that the hard copy records were ava ab e and were rev ewed dur ng the spec f c hea thcare encounter	80%	84%	39%	47%	52%	55%	***60%***
	Score Summary for SA 24:	***85%***	***93%***	***47%***	***58%***	***70%***	***64%***	***69%***

This audit is incomplete insofar that the paper record does not contain all medical record documents that are supposed to be in the paper record. This is especially true of medication administration records. In that respect, clinicians do not consistently have information related to compliance with medication available to them when they see patients. Also, the electronic record still has problems with availability of laboratory test results, intake screening information, and the current pharmacy medication profile for the patient. These deficiencies are unlikely to be corrected until an effective revised electronic record is available.

Recommendations:

1. Obtain a new electronic medical record.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JEROME DUVALL, *et al.,*	*	
Plaintiffs,	*	
v.	*	Civil Action No. ELH-94-2541
LAWRENCE HOGAN, *et al.,*	*	
Defendants.	*	

****

[PROPOSED] ORDER

****

The Court having considered Plaintiffs' Motion for Enforcement and Further Relief, and good cause appearing, IT IS ORDERED:

1. Within 30 days of this Order, Defendants shall submit a detailed plan, including timelines, for achieving compliance with each provision of the Settlement Agreement for which they concede non-compliance in the Commissioner's Semi-Annual Compliance Report, dated February 28, 2020.

2. Following the submission of Defendants' plan, the Court will schedule an evidentiary hearing to receive evidence, including but not limited to testimony from the independent medical and mental health monitors, regarding the causes of Defendants' failure to make progress in achieving compliance with numerous provisions of the Settlement Agreement.

3. The Settlement Agreement will terminate on June 22, 2024, unless Defendants reach substantial compliance with the remaining substantive portions of the Agreement, or Plaintiffs obtain an order from the Court compliant with Section IV.42(b) of the Settlement Agreement.

IT IS SO ORDERED.

Dated:

_____
Honorable Ellen L. Hollander
United States District Judge