CONTINUOUS QUALITY IMPROVEMENT MONTHLY RESULTS REPORT

PROJECT DETAILS

Name	Alameda County Sheriff Office – Medical Operations Consulting: Continuous Quality Improvement Program Review		
Sponsor	Lieutenant Joseph Atienza, Contracts Lieutenant	**Project Manager**	Tami Bond
Project Summary	To provide expanded Medical Quality Assurance (QA) services for the Alameda County Sheriff Office (ACSO) through the performance of Continuous Quality Improvement (CQI) program review and support to evaluate ongoing CQI monitoring activities, performance improvement strategies, and change implementation effectiveness. Additionally, to provide focused CQI observations and recommendations to help assure appropriate access, timeliness, and continuity of care delivery.		
Methodology	To provide CQI program and study review for the reporting period, Mazars performed medical record review of 30 incarcerated individual (patient) files against Wellpath's CQI criteria for the defined study outlined in the 2023 CQI calendar. Consistent with the Plan-Do-Study-Act (PDSA) model, Mazars performed medical record review after Wellpath's initial audit, subsequent implementation of related Improvement Plan and re-evaluation, to measure long-term performance of the improvement strategy. A compliance score of less than 90-95% threshold warrants a corrective action plan (CAP). *(See Appendix for additional Methodology and CQI program standard details)*		
Report Date	1/19/2024, 1/26/24	**Reporting Period**	11/1 – 11/30/2023
CQI Studies	Initial Health Assessment		

SUMMARY

For the reporting period of 11/1 – 11/30/2023, Mazars CQI program and study review of the Initial Health Assessment* process to determine recent change implementation effectiveness, identified additional opportunities for improvement (Observations) for the Clinical Team (Wellpath) to help assure appropriate access, timeliness, and continuity of care delivery. A total of eight criteria (Questions) for the Initial Health Assessment were measured.

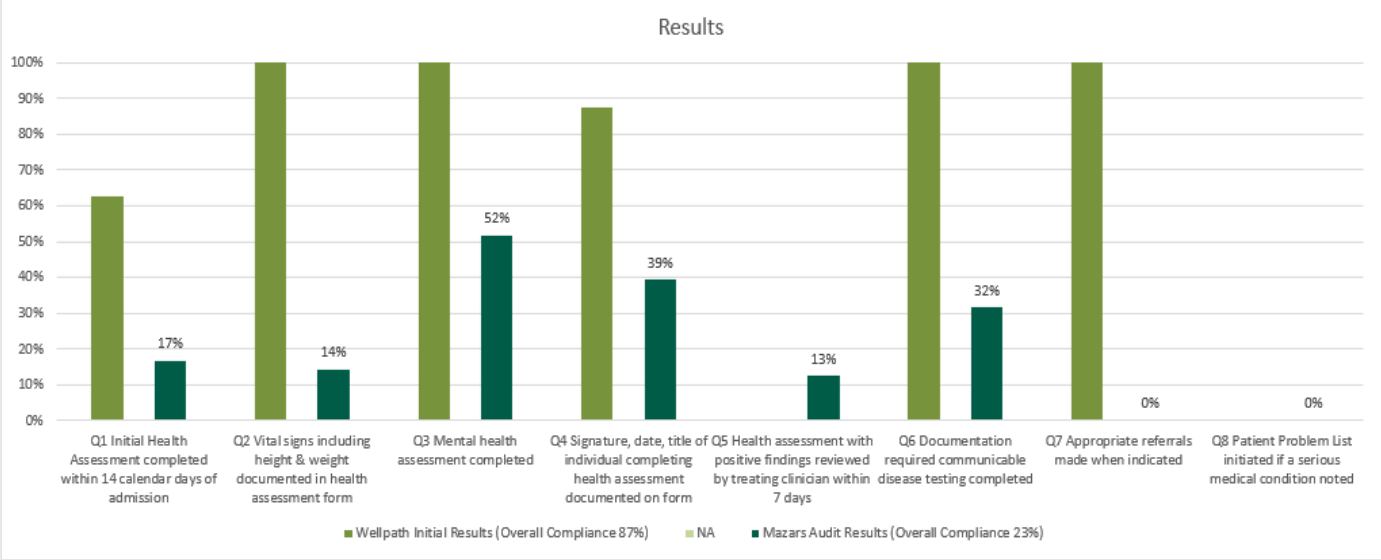
As shown in the Results graph below, Wellpath scored an overall compliance rate of 87% for Initial Health Assessment. Consistent with the Study stage of the PDSA cycle, Wellpath was required to perform a re-evaluation of its Improvement Plan implementation. The re-evaluation was intended to measure the impact of the Action Step implementation that should have included educating the nursing and provider staff on initial health assessment and clinical preventive services requirements and documentation. The required re-evaluation to be conducted by Wellpath is incomplete. Notwithstanding, Mazars performed a medical record review that resulted in a compliance rate of 23%. Due to yielding a score less than the 90-95% threshold, consistent with the Act stage of the PDSA cycle, Mazars recommends a CAP to include enhanced action steps that incorporates the observations and recommendations provided, as well as incorporate Mazars' findings into a subsequent re-evaluation within six months or more to demonstrate long-term change implementation effectiveness.

Areas of Risk:

i. Areas at risk for non-compliance that are identified to require clinical staffing management to ensure prescriber and nursing time is adequate to meet patient care delivery needs include: IHA completed within 14 calendar days of admission; Vital signs documented on health assessment form; Health assessment with positive findings reviewed by treating clinician reviewed health assessment within 7 days; Documentation required communicable disease testing completed; Problem List initiated if a serious medical condition was noted

**Reviewed in Medical QA reports sections 2.2 Specialty Referrals, 2.4 Delayed Specialty Care, and 2.7 Initial Health Assessment (IHA).*

Initial Health Assessment



CONTINUOUS QUALITY IMPROVEMENT MONTHLY RESULTS REPORT

MEDICAL RECORD REVIEW: RESULTS

	Wellpath Initial Review	*Wellpath Re-Evaluation Review*	***Mazars CQI Review Reporting Period Month***	
Date	*7/2023*	*Pending*	***11/2023***	
PDSA Model	Plan-Do	Study	**Act**	**Details for Non-Compliant Files**
Criteria	Percentage Compliant	Percentage Compliant	**Percentage Compliant**	
	goal 90-95% (# compliant/# total applicable)			
1. The initial health assessment is completed as required by contract or in compliance with national standards (within 14 days of admission from jails)?	63% (15/24)		17% (5/30)	25 of 30 files non-compliant: Patients 1, 2, 3, 4, 5, 7, 10, 13, 14, 15, 20, 24: IHA performed beyond required 14 calendar days of patient's applicable Book-In Patients 9, 11, 16, 17, 19, 21, 22, 23, 25, 26, 27, 28, 29: No evidence of IHA. "Not Started" with no evidence or untimely scanning of related patient refusal Risk for non-compliance: *Requires clinical staffing management to ensure prescriber and nursing time adequate to meet patient care delivery needs
2. Vital signs (including height and weight) are documented on the health assessment form?	100% (24/24)		14% (4/28)	24 of 28 files non-compliant: Patients 1, 2, 3, 4, 5, 7, 10, 13, 14, 18, 24: Incomplete or inconsistent documentation of vital signs Patients 9, 11, 16, 17, 19, 21, 22, 23, 25, 26, 27, 28, 29: No evidence of IHA, thereby no evidence of vital signs, height, and weight. "Not Started" with no evidence or untimely scanning of related patient refusal Risk for non-compliance: *Requires clinical staffing management to ensure prescriber and nursing time adequate to meet patient care delivery needs
3. A mental health assessment is completed?	100% (24)		52% (14/27)	13 of 27 files non-compliant: Patients 9, 11, 16, 17, 19, 21, 22, 23, 25, 26, 27, 28, 29: No evidence of IHA, thereby no evidence of mental health assessment. "Not Started" with no evidence or untimely scanning of related patient refusal.
4. The signature, date, title of the individual completing the health assessment are documented on the form?	88% (21/24)		39% (11/28)	17 of 28 files non-compliant: Patients 3, 7, 14, 18: No evidence of physician, RN, NP or PA signature, date, and title of the individual performing the physical examination and health education portions of assessment on the IHA form Patients 9, 11, 16, 17, 19, 21, 22, 23, 25, 26, 27, 28, 29: No evidence of IHA, thereby no evidence of signature, date, title of individual completing health assessment and education. "Not Started" with no evidence or untimely scanning of related patient refusal
5. If the health assessment includes positive findings, including chronic illness, the treating clinician reviewed the	0% (0/3)		13% (2/16)	14 of 16 files non-compliant: Patient 24: Inconsistent health assessment documentation – absence of mental health history vs. suicide attempt. No evidence treating clinician reviewed health assessment within 7 days (or sooner), related to reported patient suicide attempt, current Suicide Watch Alert, and Suicide History Alert. Patients 9, 11, 16, 17, 19, 21, 22, 23, 25, 26, 27, 28, 29: No evidence of IHA, thereby no evidence positive findings identified and reviewed with treating clinician.

MEDICAL RECORD REVIEW: RESULTS				
	Wellpath Initial Review	*Wellpath Re-Evaluation Review*	***Mazars CQI Review Reporting Period Month***	
Date	*7/2023*	*Pending*	***11/2023***	
PDSA Model	Plan-Do	Study	**Act**	**Details for Non-Compliant Files**
Criteria	Percentage Compliant	Percentage Compliant	**Percentage Compliant**	
	goal 90-95% (# compliant/# total applicable)			
health assessment within 7 days?				"Not Started" with no evidence or untimely scanning of related patient refusal Risk for non-compliance: *Requires clinical staffing management to ensure prescriber and nursing time adequate to meet patient care delivery needs
6. There is documentation that required communicable disease testing has been completed?	100% (2/2)		32% (6/19)	13 of 19 files non-compliant: Patients 9, 11, 16, 17, 19, 21, 22, 23, 25, 26, 27, 28, 29: No evidence of IHA, thereby no evidence of communicable disease testing. "Not Started" with no evidence or untimely scanning of related patient refusal Risk for non-compliance: *Requires clinical staffing management to ensure prescriber and nursing time adequate to meet patient care delivery needs
7. Appropriate referrals are made when indicated?	100% (18/18)		0% (0/19)	19 of 19 files non-compliant: Patient 20: No evidence appropriate referral made for Eye Clinic Patients 3, 7, 14, 18: Inconsistent documentation of referral requests, including Mental Health Patient 24: Delayed Mental Health referral to AFBH for reported Suicide Attempt, Suicide History and Suicide Watch Alerts, and multiple Sick Calls for attempted suicide Patients 9, 11, 16, 17, 19, 21, 22, 23, 25, 26, 27, 28, 29: No evidence of IHA, thereby no evidence of appropriate referrals made. "Not Started" with no evidence or untimely scanning of related patient refusal
8. Was a patient Problem List initiated if a serious medical condition was noted?	N/A		0% (0/13)	13 of 13 files non-compliant: Patients 9, 11, 16, 17, 19, 21, 22, 23, 25, 26, 27, 28, 29: No evidence of IHA, thereby no evidence Problem List initiated from IHA. "Not Started" with no evidence or untimely scanning of related patient refusal Risk for non-compliance: *Requires clinical staffing management to ensure prescriber and nursing time adequate to meet patient care delivery needs

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
1. The initial health assessment is completed as required by contract or in compliance with national standards (within 14 days of admission from jails)?	Observation: Approximately half of the applicable patient files reviewed showed inconsistent and untimely Initial Health Assessments (IHA), within the required 14-calendar days of a patient's intake to the facility. Additionally, more than half of the IHA forms were not started with no evidence or untimely scanning of patient refusals. Site policy requires the Initial Health Assessment be completed as soon as possible, but no later than 14 calendar days after admission (HCD-110_E-04). NCCHC standards require the Full Population Initial Health Assessment to occur as soon as possible, but no later than 14 calendar days after admission. Without a complete and/or timely initial medical history and physical exams, the Clinical Teams cannot establish an appropriate and individualized care plan to responsibly care for the patient, appropriately identify and assure patient health care needs are met and meet applicable policy, procedure, and standards requirements. Recommendation: • Identify and address current challenges preventing timely and adequate assessment for each patient • Hold Clinical Staff accountable for the completion of IHA, applicable related patient refusal forms, to provide appropriate and timely coordinated care to patients • Continue to perform ongoing auditing and monitoring of Initial Health assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs
2. Vital signs are documented on the health assessment form?	Observation: Approximately half of the applicable patient files reviewed showed incomplete or inconsistent documentation of vital signs. Mazars observed vital signs collected and documented by an LVN on a Sick Call in lieu of on the IHA form. No additional evidence of height and weight measurements were documented, as required by NCCHC standards and site policy. Additionally, more than half of the IHA forms were not started within the required 14-calendar days of a patient's intake to the facility with no evidence or untimely scanning of patient refusals, thereby vital signs were missing. Without a complete and/or timely initial medical history and physical exams, including vital signs, height, and weight, the Clinical Teams cannot establish an appropriate and individualized care plan with baseline measurements, to responsibly care for the patient, appropriately identify and assure patient health care needs are met and meet applicable policy, procedure, and standards requirements. Recommendation: • Identify and address current challenges preventing timely and adequate assessment for each patient • Hold Clinical Staff accountable for the completion of IHA, including vital signs, height, and weight, applicable related patient refusal forms, to provide appropriate and timely coordinated care to patients • Continue to perform ongoing auditing and monitoring of Initial Health assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs
3. A mental health assessment is completed?	Observation: Approximately half of the applicable patient files reviewed showed that the IHA forms were not started within the required 14-calendar days of a patient's intake to the facility with no evidence or untimely scanning of patient refusals, thereby mental health assessments were missing. Without a complete and/or timely initial medical history, physical exams, and mental health assessment, the Clinical Teams cannot establish an appropriate and individualized care plan to responsibly care for the patient, appropriately identify and assure patient health care needs are met and meet applicable policy, procedure, and standards requirements. Recommendation: • Identify and address current challenges preventing timely and adequate assessment for each patient • Hold Clinical Staff accountable for the completion of IHA, and minimally a referral to AFBH for mental health assessment, applicable related patient refusal forms, to provide appropriate and timely coordinated care to patients

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
	• Continue to perform ongoing auditing and monitoring of Initial Health assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs
4. The signature, date, title of the individual completing the health assessment are documented on the form?	Observation: Mazars observed for some patient files, the IHA's were reported to be completed however the forms showed incomplete assessment with no evidence of a physical examination performed or related patient refusal. NCCHC standards and site policy require a physical examination be performed by a physician, physician assistant, nurse practitioner, or registered nurse. Additionally, some of the patient files reviewed showed incomplete documentation, including missing assessments, physical examination, and health education, as well as the required signature, date, and title of the individual completing the assessment. Approximately half of the patient files reviewed showed that the IHA forms were not started within the required 14-calendar days of a patient's intake to the facility with no evidence or untimely scanning of patient refusals, thereby signature, date, title was missing. Without a complete and/or timely initial medical history, physical exams, and mental health assessment, including signature, date, title of individual completing the health assessment documentation, the Clinical Teams cannot establish an appropriate and individualized care plan to responsibly care for the patient, appropriately identify and assure patient health care needs are met and meet applicable policy, procedure, and standards requirements. Recommendation: • Identify and address current challenges preventing timely and adequate assessment for each patient • Hold Clinical Staff accountable for the completion of IHA, including documentation of signature, date, and title of individual completing the health assessment, applicable related patient refusal forms, to provide appropriate and timely coordinated care to patients • Continue to perform ongoing auditing and monitoring of Initial Health assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs
5. If the health assessment includes positive findings, including chronic illness, the treating clinician reviewed the health assessment within 7 days?	Observation: One patient file reviewed showed patient report of suicide attempt with documented Suicide History and Suicide Watch Alerts. No evidence IHA was reviewed by a treating clinician within 7 days. Delayed clinical review of IHA positive findings, including chronic illness, increases the risk for poor patient outcome(s), injury and/or harm. The treating clinician and care team are at risk for the provision of inadequate care, inappropriate care, delayed care, and/or uncoordinated care. Approximately half of the patient files reviewed showed that the IHA forms were not started within the required 14-calendar days of a patient's intake to the facility with no evidence or untimely scanning of patient refusals, thereby positive findings requiring treating clinician review was missing. Without a complete and/or timely initial medical history, physical exams, and mental health assessment, the Clinical Teams cannot establish an appropriate and individualized care plan to responsibly care for the patient, appropriately identify and assure patient health care needs are met and meet applicable policy, procedure, and standards requirements. Recommendation: • Identify and address current challenges preventing timely and adequate assessment for each patient • Hold Clinical Staff accountable for the completion of IHA, and referring to treating clinician to review positive findings, applicable related patient refusal forms, to provide appropriate and timely coordinated care to patients • Continue to perform ongoing auditing and monitoring of Initial Health assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs
6. There is documentation that required communicable disease testing has been completed?	Observation: Approximately half of the patient files reviewed showed that the IHA forms were not started within the required 14-calendar days of a patient's intake to the facility with no evidence or untimely scanning of patient refusals, thereby communicable disease testing documentation was missing. Without a complete and/or timely initial medical history, physical exams, and mental health assessment, the Clinical Teams cannot establish an

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
	appropriate and individualized care plan to responsibly care for the patient, appropriately identify and assure patient health care needs are met and meet applicable policy, procedure, and standards requirements. Recommendation: • Identify and address current challenges preventing timely and adequate assessment for each patient • Hold Clinical Staff accountable for the completion of IHA, including documentation of required communicable disease testing, applicable related patient refusal forms, to provide appropriate and timely coordinated care to patients • Continue to perform ongoing auditing and monitoring of Initial Health assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs
7. Appropriate referrals are made when indicated?	Observation: One patient file reviewed showed Specialty Care referral for Eye Clinic was missing. Additionally, some of the patient files reviewed showed inconsistent documentation of Specialty Care referrals, including Mental Health. Another patient file reviewed showed delayed Mental Health referral to AFBH for patient report of suicide attempt with documented Suicide History and Suicide Watch Alerts. Approximately half of the patient files reviewed showed that the IHA forms were not started within the required 14-calendar days of a patient's intake to the facility with no evidence or untimely scanning of patient refusals, thereby mental health assessments were missing. Without a complete and/or timely initial medical history, physical exams, and mental health assessment, the Clinical Teams cannot establish an appropriate and individualized care plan to responsibly care for the patient, appropriately identify and assure patient health care needs are met and meet applicable policy, procedure, and standards requirements. Recommendation: • Continue to hold Clinicians and Clinical Staff accountable for the appropriate identification and documentation of the required Specialty Care Referrals • Identify and address current challenges preventing timely review of completed IHA • Hold Clinical Staff accountable for the completion of IHA, appropriate referral selection, applicable related patient refusal forms, to provide appropriate and timely coordinated care to patients • Continue to perform ongoing auditing and monitoring of Initial Health assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs
8. Was a patient Problem List initiated if a serious medical condition was noted?	Observation: Approximately half of the patient files reviewed showed that the IHA forms were not started within the required 14-calendar days of a patient's intake to the facility with no evidence or untimely scanning of patient refusals, thereby patient Problem List was missing. Without a complete and/or timely initial medical history, physical exams, and mental health assessment, specifying acute patient problems, the Clinical Teams cannot establish an appropriate and individualized care plan to responsibly care for the patient, appropriately identify and assure patient health care needs are met and meet applicable policy, procedure, and standards requirements. Recommendation: • Identify and address current challenges preventing timely and adequate assessment for each patient • Hold Clinical Staff accountable for the completion of IHA, including patient problem list, applicable related patient refusal forms, to provide appropriate and timely coordinated care to patients • Continue to perform ongoing auditing and monitoring of Initial Health assessment form. Report results of auditing and monitoring to the ACSO • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs

APPENDIX

PROJECT DETAILS

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

METHODOLOGY

A. CONTINUOUS QUALITY IMPROVEMENT STUDY REVIEW

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

For the CQI study reporting period*, Mazars conducted medical record review of 30 incarcerated individual (patient) files against Wellpath's CQI criteria for the defined studies outlined in the 2023 CQI calendar and guidance. Mazars performed medical record review after Wellpath's scheduled initial audit and implementation of a related Improvement Plan. Wellpath's subsequent re-evaluation is pending completion. Mazars performed the review to examine change implementation effectiveness and long-term performance of the improvement strategy, consistent with the widely used Plan-Do-Study-Act (PDSA) model:

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

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

<u>November 2023 CQI Study – Initial Health Assessment:</u>

- **Plan-Do** – Wellpath performed the following activities:
  - Audited 24 patient records during the 6/1 – 6/30/2023 date range, against the following criteria:
    1. The initial health assessment is completed as required by contract or in compliance with national standards (within 14 days of admission from jails)?
    2. Vital signs are documented on the health assessment form?
    3. A mental health assessment is completed?
    4. The signature, date, title of the individual completing the health assessment are documented on the form?
    5. If the health assessment includes positive findings, including chronic illness, the treating clinician reviewed the health assessment within 7 days?
    6. There is documentation that required communicable disease testing has been completed?
    7. Appropriate referrals are made when indicated?
    8. Was a patient Problem List initiated if a serious medical condition was noted?
  - Established compliance threshold of 90 - 95%
  - ***Wellpath has not developed or shared the required Improvement Plan based on initial audit score***
- **Study** – Wellpath did not conduct the re-evaluation of Initial Health Assessment
- **Act** – For this November 2023 reporting period*, Mazars performed the following activities:
  - Evaluated 30 patient files against the Initial Health Assessment criteria during the 11/1/2023 – 11/30/2023 reporting period, to evaluate continued compliance
  - Provided focused CQI observations and recommendations for a CAP, including enhanced action steps and re-evaluation

**The "reporting period" refers to the month included in the timeframe that patient files were selected for the specified CQI study noted above*

METHODOLOGY

B. CONTINUOUS QUALITY IMPROVEMENT PROGRAM GUIDANCE

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

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

As part of a continuous quality improvement (CQI) Program, Full Population Initial Health Assessment is performed on all patients as soon as possible, but no later than 14 calendar days after admission to ensure that health care needs are met as aligned with evidence-based standards (NCCHC essential standard J-E-04)

METHODOLOGY

- Compliance Indicators:
  1. Receiving screening results are reviewed within 14 days
  2. All patients receive an initial health assessment as soon as possible, but no later than 14 calendar days after admission
  3. If the health assessment is deferred because of a documented health assessment within the last 12 months, documentation in the health record must confirm that the new receiving screening shows no change in health status
     a. If the receiving screening shows a change in health status, the initial health assessment is repeated
  4. The responsible physician determines the components of and initial health assessment
  5. Initial health assessments include, at a minimum:
     a. A qualified health care professional collecting additional data to complete the medical, dental, and mental health histories, including any follow-up from abnormal findings obtained during the receiving screening and subsequent encounters
     b. A qualified health care professional recording of vital signs (including height and weight)
     c. A physical examination (as indicated by the patient's gender, age, and risk)
     d. A screening test for latent tuberculosis (e.g., PPD, chest x-ray, laboratory test), unless, completed prior to the initial health assessment
  6. All abnormal findings (i.e., history and physical, screening, and laboratory) are reviewed by the provider
  7. Specific problems are integrated into an initial problem list
  8. Diagnostic and therapeutic plans for each problem are developed as clinically indicated
  9. All aspects of the standard are addressed by written policy and defined procedures

C. APPLICABLE POLICY AND PROCEDURE

NCCHC standards require Full Population Initial Health Assessment is performed on all patients as soon as possible, but no later than 14 calendar days after admission

Wellpath Policy and Procedure HCD-110_E-04 Initial Health Assessment-Alameda CA requires patients receive an initial health assessment as soon as possible, but no later than 14 calendar days after admission to the facility. The health evaluation will include at the least the following:

- Review of the receiving screening results
- A qualified health care professional collecting additional data to complete the medical, dental, and mental health histories, including any follow-up from positive findings obtained during receiving screening and subsequent encounters
- A qualified health care professional recording of vital signs (including height, weight, pulse, blood pressure, and temperature)
- A physical examination (as indicated by the patient's gender, age, and risk factors) – inspection, palpation, auscultation, and percussion of a patient's body to determine the presence or absence of physical signs of illness
- Laboratory and/or diagnostic tests for communicable diseases such as tuberculosis and syphilis, if not completed at the time of receiving screening, unless there is documentation from the health department that the prevalence rate does not warrant it
- Immunizations when appropriate
- Completion of other clinically indicated tests and examinations
- Initiation of appropriate treatment when indicated or ordered by the physician
- When applicable, development and implementation of a treatment plan, including recommendations for housing, job assignments, and program participation
- Vision screening: Vision screening results at 20/70 or higher will result in referral to the provider for possible Optometry referral, when appropriate
- Positive findings (e.g., history and physical screening, and laboratory) are reviewed by the provider. Specific problems are integrated into an initial problem list. Diagnostic and therapeutic plans for each problem are developed as clinically indicated
- HIV testing will be offered to patients, with their consent, who have related symptoms, high-risk behaviors, or request that they be tested
- A physician, physician assistant, nurse practitioner, or appropriately trained registered nurse completes the hands-on portion of the health assessment. The responsible Physician / Medical Director documents his or her review of the health assessment when positive findings are present