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	05/14/2024	**Reporting Period**	12/1/2023 - 2/29/2024
CQI Studies	Diabetes - HEDIS		

SUMMARY

For the reporting period of 12/1/2023 - 2/29/2024, Mazars CQI program and study review of the Diabetes-HEDIS* processes to determine recent change implementation effectiveness, identified additional opportunities for improvement (Observations) for the Clinical Team (Wellpath) to help assure appropriate access, timeliness, and continuity of care delivery. A total of five criteria (Questions) for Diabetes-HEDIS were measured.

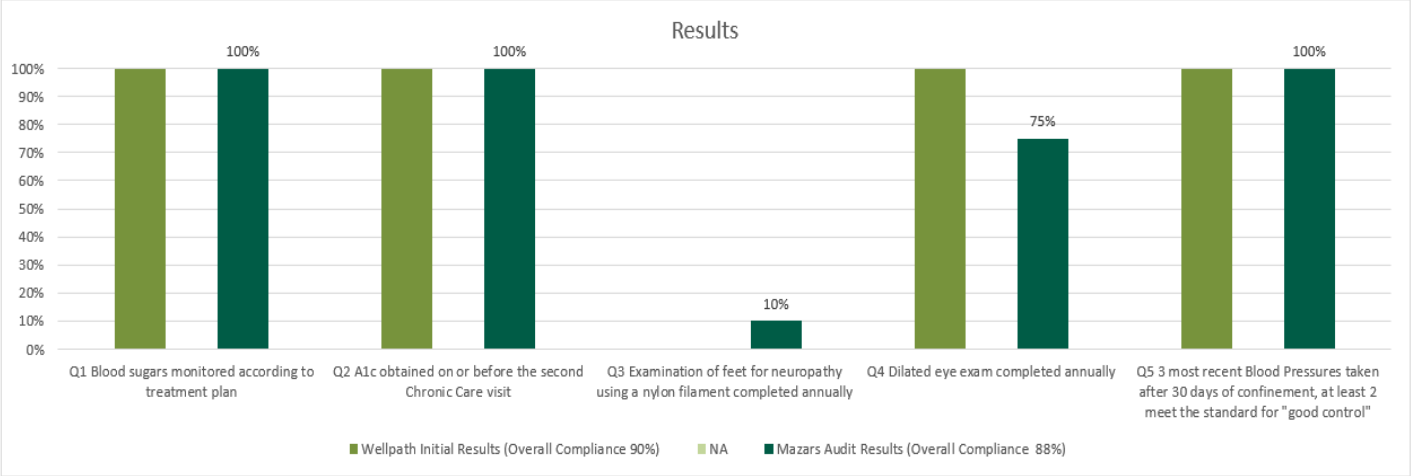
As shown in the Results graph below, Wellpath scored an overall compliance rate of 90% for Diabetes-HEDIS. Although Wellpath scored a total compliance score of 90% for the Initial Review, one of the five criteria did not meet the compliance threshold of 90%. As a result, no improvement plan was developed, and no subsequent re-evaluation was performed for the one deficiency. Notwithstanding, Mazars performed a medical record review that resulted in a compliance rate of 88%. 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 noncompliance identified to require operational efficiency to meet patient care delivery needs include: Timely blood sugar monitoring is evidenced; Completed Annual Dilated Eye Exams

**Reviewed in Medical QA reports sections 2.4 Delayed Specialty Care and 2.6 Delays and Appropriateness of Ongoing Medical Care.*

Diabetes-HEDIS



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MEDICAL RECORD REVIEW: RESULTS

	Wellpath Initial Review	*Wellpath Re-Evaluation Review*	***Mazars CQI Review Reporting Period Month***	
Date	*9/2023*		***4/2024***	
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. Is there evidence that blood sugars are monitored in accordance with the treatment plan? [90% compliance]	100% (24/24)	NA	100% (30/30)	Compliant <u>Risk for non-compliance:</u> <u>Patient 21</u>: Delay in care. Multiple sick calls submitted by patient for blurry vision and leg pain. Delay in identifying potential symptoms as evidenced by medical sick calls. Psychiatrist ordered lab draw and prompted medical provider to initiate initial chronic care visit
2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract? [95% compliance]	100% (22/22)	NA	100% (29/29)	Compliant.
3. An examination of feet for neuropathy using a nylon filament is completed annually on patients confined at least 12 months? [90% compliance]	0% (0/8)	Pending	10% (1/10)	9 of 10 files non-compliant: <u>Patients 1, 6, 9, 16, 19, 21, 27, 29</u>: No documented evidence of a nylon filament used annually as part of examination of the feet for neuropathy <u>Patient 3</u>: Inconsistent annual documentation of use of a nylon filament as part of examination of the feet
4. A dilated eye exam is completed annually? [95% compliance]	100% (6/6)	NA	75% (15/20)	5 of 20 files non-compliant: <u>Patients 2, 3, 6, 19, 26</u>: No evidence dilated eye exam completed annually <u>Risk for non-compliance:</u> <u>Patients 1, 4, 7, 9, 16, 21</u>: Delay in care. Dilated eye exams not consistently performed and completed, showing multiple rescheduled appointments
5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet	100% (24/24)	NA	100% (30/30)	Compliant

MEDICAL RECORD REVIEW: RESULTS

	Wellpath Initial Review	*Wellpath Re-Evaluation Review*	***Mazars CQI Review Reporting Period Month***	
Date	*9/2023*		***4/2024***	
PDSA Model	Plan-Do	Study	**Act**	**Details for Non-Compliant Files**
Criteria	Percentage Compliant	Percentage Compliant	**Percentage Compliant**	
	goal 90-95% (# compliant/# total applicable)			
the standard for "good control"? [72% compliance]				

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS

1. Is there evidence that blood sugars are monitored in accordance with the treatment plan?	Criteria met Observation: While the criteria was met for this measure, Mazars' review of one patient file showed a risk for noncompliance related to a delay in care. Several months into the patient's booking, multiple sick calls were placed by the patient with complaints of blurry vision and leg pain. A psychiatrist placed an order for a lab draw; subsequent lab results showed elevated hemoglobin A1c, glucose level, and lipid levels. No documented evidence of follow up related to abnormal lab results by medical provider until prompted by psychiatrist one month later resulting in a delay in care. Inability to provide timely and appropriate care in accordance with clinical practice standards and policy increases the risk for inadequate care, inappropriate care, delayed care, and uncoordinated care, which could negatively impact patient outcome(s) and result in patient injury and/or harm. Recommendation: • Continue to collaborate with multidisciplinary teams to help ensure all patient care needs are met • Implement enhanced data integration solution(s) for bidirectional information sharing across applicable systems beyond current interfaces, between Wellpath medical (CorEMR), ACSO corrections (ATIMS), AFBH behavioral health (Gateway), and Maxor pharmacy (Guardian) • Continue to perform ongoing auditing and monitoring. Report results of auditing and monitoring to the ACSO
2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract?	Criteria met
3. An examination of feet for neuropathy using a nylon filament is completed annually on patients confined at least 12 months?	Observation: Mazars' review of the selected patient files who have been confined at least 12 months or more showed no documented evidence of a nylon filament used as part of the examination of the patients' feet. However, Mazars observed provider assessment documentation, evaluating the patients' feet for neuropathy and open wounds. Adequate evaluation and consistent documentation of early assessment symptoms of neuropathy helps prevent disease process complications, and patient injury and/or harm. Recommendation: • Re-evaluate need for examination of feet using nylon filament against evidence-based practice or HEDIS requirements; update applicable policy and procedure and standard of practice accordingly • Continue to perform ongoing auditing and monitoring. Report results of auditing and monitoring to the ACSO
4. A dilated eye exam is completed annually	Observation: Mazars observed that for several of the patient files reviewed, an annual dilated eye exam was not ordered, performed, and completed. For several other patient files reviewed, there was delay in care by several months of obtaining an eye exam, with multiple

CQI MEDICAL RECORD REVIEW: OBSERVATIONS AND RECOMMENDATIONS	
	rescheduled appointments. Additionally, justification details for rescheduled appointments were not consistently documented. Inability to provide timely and appropriate care in accordance with clinical practice standards and policy increases the risk for inadequate care, inappropriate care, delayed care, and uncoordinated care, which could negatively impact patient outcome(s) and result in patient injury and/or harm. <u>Recommendation:</u> • Continue Improvement Plan implementation to require appropriate and timely care delivery, in collaboration with Specialists • Consider implementing eye clinic triage process to prioritize treatment visits as appropriate • Collectively develop a list of justification reasons to reschedule an appointment, socialize, and implement across all disciplines • Hold Specialists accountable for inadequate care and/or delayed care • Continue multi-disciplinary partnerships to improve care coordination: Wellpath medical, ACSO corrections, AFBH behavioral health, and Specialists to uniformly manage and share information across teams and systems • Reassess clinical staffing plan to ensure prescriber and nursing time sufficient to meet patient care delivery needs • Continue to perform ongoing auditing and monitoring of care delivery appropriateness, timeliness, care coordination. Report results of auditing and monitoring to the ACSO
5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet the standard for "good control"?	Criteria met

APPENDIX

PROJECT DETAILS

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

METHODOLOGY

A. CONTINUOUS QUALITY IMPROVEMENT STUDY REVIEW

As described in the Project Details section, to provide expanded Medical Quality Assurance (QA) services for the ACSO, 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>April 2024 CQI Study – Diabetes-HEDIS:</u>

- **Plan-Do** – Wellpath performed the following activities:
  - Audited 24 patient records during the 7/26/23 – 9/26/2023 date range, against the following criteria:
    1. Is there evidence that blood sugars are monitored in accordance with the treatment plan?
    2. Was the A1c obtained on or before the second Chronic Care visit, unless required sooner by the contract?
    3. An examination of feet for neuropathy using a nylon filament is completed annually on patients confined at least 12 months?
    4. A dilated eye exam is completed annually?
    5. Of the 3 most recent Blood Pressures taken after 30 days of confinement, at least 2 meet the standard for "good control"?
  - Established compliance threshold of 90-95%
  - Wellpath has not developed or shared the required Improvement Plan based on one non-compliant criteria
- **Study** – Wellpath did not conduct the re-evaluation of Diabetes-HEDIS for one deficient criteria
- **Act** – For this April 2024 reporting period*, Mazars performed the following activities:
  - Evaluated 30 patient files against the Diabetes-HEDIS criteria during the 12/1/2023 – 2/29/2024 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*

B. CONTINUOUS QUALITY IMPROVEMENT PROGRAM GUIDANCE

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

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

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

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

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

C. APPLICABLE POLICY AND PROCEDURE

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

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