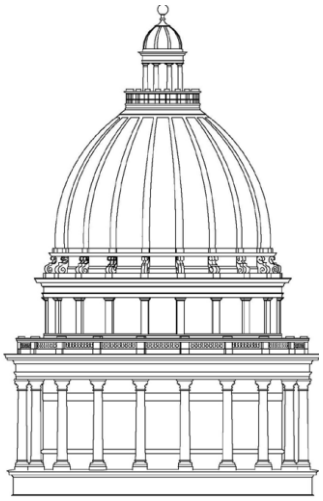
REPORT TO THE

UTAH LEGISLATURE

Number 2021-17



A Performance Audit of Healthcare in State Prisons

December 2021

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH

Office of the Legislative Auditor General

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KADE R. MINCHEY, CIA, CFE
AUDITOR GENERAL

December 7, 2021

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of Healthcare in State Prisons** (Report #2021-17). An audit summary is found at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade Minchey

Kade R. Minchey, CIA, CFE
Auditor General

UTAH STATE LEGISLATURE

AUDIT SUMMARY

REPORT #2021-17 | DECEMBER 2021

Office of the Legislative Auditor General | Kade R. Minchey, Auditor General

Audit of Healthcare in State Prisons

PERFORMANCE AUDIT

AUDIT REQUEST

The Legislative Audit Subcommittee requested that we evaluate the quality, efficiency, and effectiveness of healthcare services administered in Utah's prison system and determine if any medical neglect has occurred and to what degree. In addition, we were asked to review how effectively COVID-19 concerns were addressed.

BACKGROUND

The Clinical Services Bureau (Bureau) provides healthcare services to over 5,000 inmates who reside within the Utah Department of Corrections (UDC). The Bureau is responsible for providing medical, mental health, dental, and optometry services to the inmates at the Utah State Prison (USP or Draper prison site) and the Central Utah Correctional Facility (CUCF or Gunnison prison site). The Bureau operates infirmaries at both locations and a pharmacy is located at the Draper site.

KEY FINDINGS

- As part of this audit, our medical consultant reviewed 76 sampled cases and determined that several inmates were given inappropriate or inadequate care.
- The lack of follow-up and patient monitoring is problematic and medical charts lack sufficient information.
- Inmates with diabetes are not adequately monitored and the amount of time between insulin distribution and mealtime does not follow internal protocols or meet professionally recognized standards.
- Clinical Services Bureau is not fully compliant with national accreditation (NCCHC) standards.
- Administrative oversight of medical services needs to improve.

Management Needs to Improve Systemic Deficiencies within Clinical Services

Our review of the Utah state prison system's Clinical Services Bureau (Bureau) found several systemic deficiencies that negatively impacted patient outcomes. Systemic deficiencies, at times, threaten the level of care provided. In most cases, inmates received competent medical care. Unfortunately, in other cases, systemic deficiencies significantly delayed or degraded the level of care provided.

RECOMMENDATIONS

- We recommend that management improve systemic deficiencies within the Clinical Services Bureau.
- We recommend that the Bureau ensure that all patients have access to: (1) Appropriate and timely clinical judgements rendered by a qualified healthcare professional, and (2) Correct treatments and medications for corresponding diagnoses.
- We recommend that the Bureau follow all internal policies, internal protocols, professionally recognized standards, and best practices regarding the administration and application of healthcare to inmates.

Summary continues on back >>

REPORT SUMMARY

Management Can Improve Its Compliance With Statute and Standards

The Utah Department of Corrections (UDC) prison healthcare system needs improvement. In this audit, we address several areas of concern and provide recommendations for improvement. The following bullet points summarize our findings:

- Statutorily required national accreditation standards are not consistently being met.
- Bureau management is using EMTs in situations that they have not been adequately trained for. We question whether the use of EMTs in a nonemergency setting places them in situations beyond their limited clinical training and education.
- Personal health information is not adequately protected per state statute and national standards.
- The Bureau is not following the inmate handbook fee schedule regarding mental health copays.

Administrative Oversight of Medical Services Needs to Improve

The primary reason for the Bureau's systemic deficiencies is inadequate oversight from multiple levels of personnel. More specifically, Bureau management:

- Lacks financial controls, as individual incentive award programs circumvent Administrative Rule.
- Lacks transparency in funding allocations.
- Reports incorrect performance metric data to the Legislature for program performance metrics that do not reflect actual program operations.
- Has not updated several of the Bureau's policies, procedures, and training materials.

Management Needs to Ensure That Personal Health Information Is Protected and Unused Medications Are Secure

We found patient treatment sheets, pill packets containing personal health information, and a used syringe in two public dumpsters located outside the prison. Four weeks later, a second inspection found more pill packets containing personal health information and unused medications. Medications in pill packets that are stamped "retained" are to be retained by clinical staff and returned to the pharmacy. These pills, if unopened, can be reused by the pharmacy.

REPORT TO THE
UTAH LEGISLATURE

Report No. 2021-17

A Performance Audit of Healthcare in State Prisons

December 2021

Audit Performed By:

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Chapter I
Introduction

The Clinical Services Bureau (Bureau, or prison medical) provides healthcare services to more than 5,000 inmates under the jurisdiction of the Utah Department of Corrections (UDC). The Bureau is statutorily required to be compliant with National Commission for Correctional Health Care (NCCHC) standards. The Bureau provides medical, mental health, dental, and optometry services to inmates at the Utah State Prison (USP, or Draper prison site) and the Central Utah Correctional Facility (CUCF, or Gunnison prison site). The Bureau operates infirmaries at both locations and a pharmacy at the Draper prison site.

Medical Services Are Provided By the Department of Corrections

USP contracts with the University of Utah Hospital and CUCF contracts with the Gunnison Valley Hospital for medical services.

Medical staff at USP and CUCF are responsible for the healthcare of all Utah state inmates. Both facilities utilize outside medical services when they do not have the internal expertise to meet the needs of their patients. For example, USP contracts with the University of Utah Hospital, and CUCF contracts with the Gunnison Valley Hospital.

Because of geographic location, the Draper prison has been designated to provide medical care to those with more acute medical needs and, therefore, has more resources available to serve a larger population of inmates. USP also has access to telemedicine, which allows inmates to be evaluated by outside specialists in a live-video conference setting. The telemedicine clinics[1] preserve resources and reduce the risk of transporting inmates to offsite locations. Figure 1.1 summarizes the number of medical and mental health personnel at both prison locations.

[1] The Wasatch Infirmary, located at the Draper prison site, has 11 telemedicine specialty clinics including hepatology, nephrology, neurology etc. The telemedicine system allows inmates to be evaluated and followed by off-site specialists.

The Draper prison site has more medical personnel because it has a larger inmate population.

Figure 1.1 Medical Personnel at the Draper and Gunnison Prison Sites. The Draper prison site has more medical personnel because it has a larger inmate population and has a greater share of inmates with acute medical needs.

	Employee Count[2]	
Medical & Mental Health Personnel	**Draper**	**Gunnison**
Doctor (3 doctors, one practicing medical director*)	3	1
Physician Assistant	8	2
Nurse	42	19
Psychiatrist*	1	-
Psychologist*	2	-
Supervising Psychologist	1	-
Therapist Supervisor	4	1
Clinical Therapist	7	1
Optometrist*	1	-
Physical Therapist*	1	-
Dietician*	1	-
Emergency Medical Technician (EMT)	22	2
TOTAL	**93**	**26**

Source: Department of Human Resource Management
** Employees are shared by both facilities.*

While Figure 1.1 is not a comprehensive list, it accounts for most medical and mental health personnel at both facilities.

ICRs Are the Main Mechanism Available for Inmates to Request Medical Services

Inmates at both the Draper and Gunnison prison sites submit inmate healthcare requests (ICRs) to request medical, mental health, dental, or optometry services. ICR forms filled out by inmates can be submitted to a secure collection box, or directly to UDC staff. The form allows inmates to request the following services:

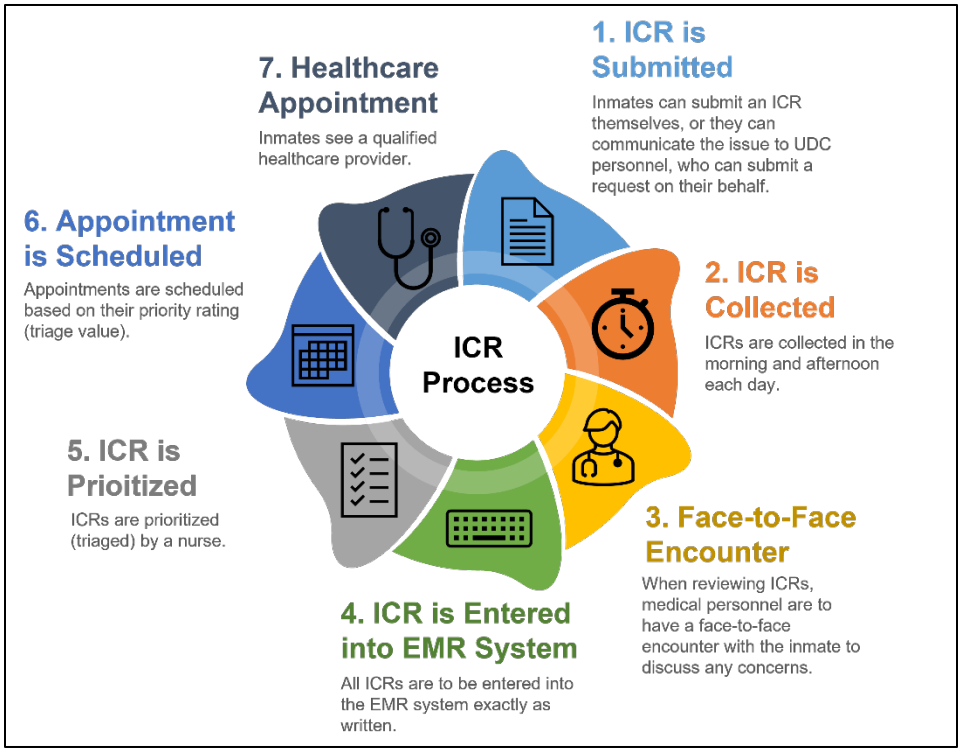
- Medical visit
- Mental health visit

[2] The employee count includes the number of full-time equivalent (FTE) positions as of August 23, 2021.

- Dental visit
- Medication renewal
- Mental health medication renewal
- Information (questions about a recent test or procedure)
- Optometry visit

The form also has space for inmates to write additional notes. The inmate dates the form and provides their name, inmate number, and housing unit. Figure 1.2 illustrates the step-by-step process from when an ICR is submitted to when an inmate is seen by a qualified healthcare provider.

Figure 1.2 The ICR Process Allows Inmates to Initiate a Healthcare Request. ICRs can be verbally communicated to UDC personnel but must be entered into the electronic medical record system so that an appointment with a healthcare provider can be scheduled.



Source: Auditor generated

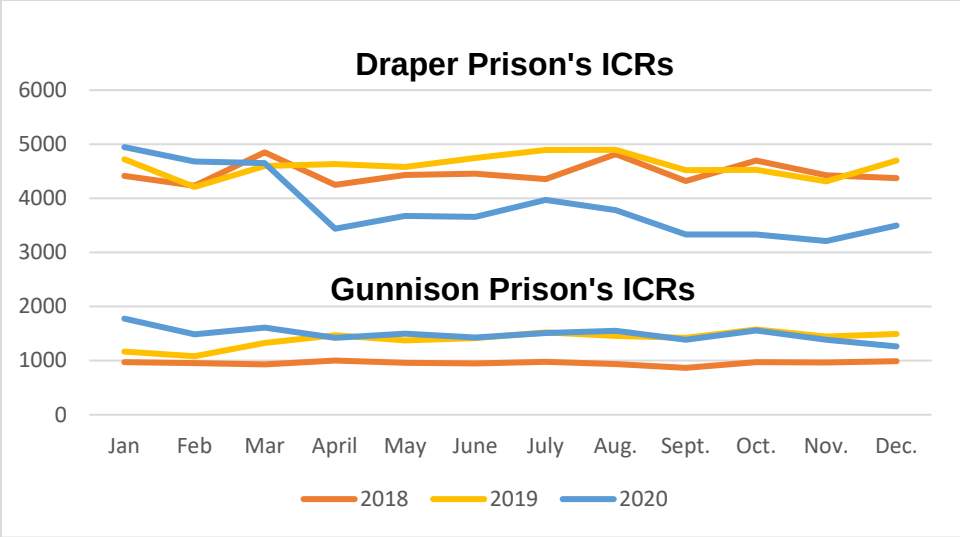
Inmate healthcare requests (ICRs) can be verbally communicated to UDC personnel but must be entered into the electronic medical record system.

ICRs are collected twice daily at pill lines[3] by emergency medical technician (EMT) staff. Figure 1.3 illustrates the number of monthly

[3] Pill lines are designated places in the facility where inmates who require medications that must be more carefully monitored are given their daily dosages. Pill lines are held twice daily.

ICRs that were processed at the Draper and Gunnison prison sites between calendar years 2018 and 2020.

Figure 1.3 Total Number of Monthly ICRs Received by the Draper and Gunnison Prisons for Calendar Years 2018 to 2020. The Draper prison site averaged 3,879 ICRs a month in 2020, whereas the Gunnison prison site averaged 1,490 ICRs a month in 2020.



Source: Auditor generated

The Draper prison receives more ICRs since they house more inmates than the Gunnison prison.

At the beginning of March 2020, the total inmate population was just over 3,300 for the Draper prison and 1,700 for the Gunnison prison. The average number of ICRs per capita is close to one ICR per person per month at both prison locations. Once an ICR is entered into the system, it is triaged (or prioritized) by a nurse.[4] After the ICR is triaged, the inmate will be scheduled to see a provider as needed.[5]

Bureau Expenses Consistently Exceed Appropriation Amounts

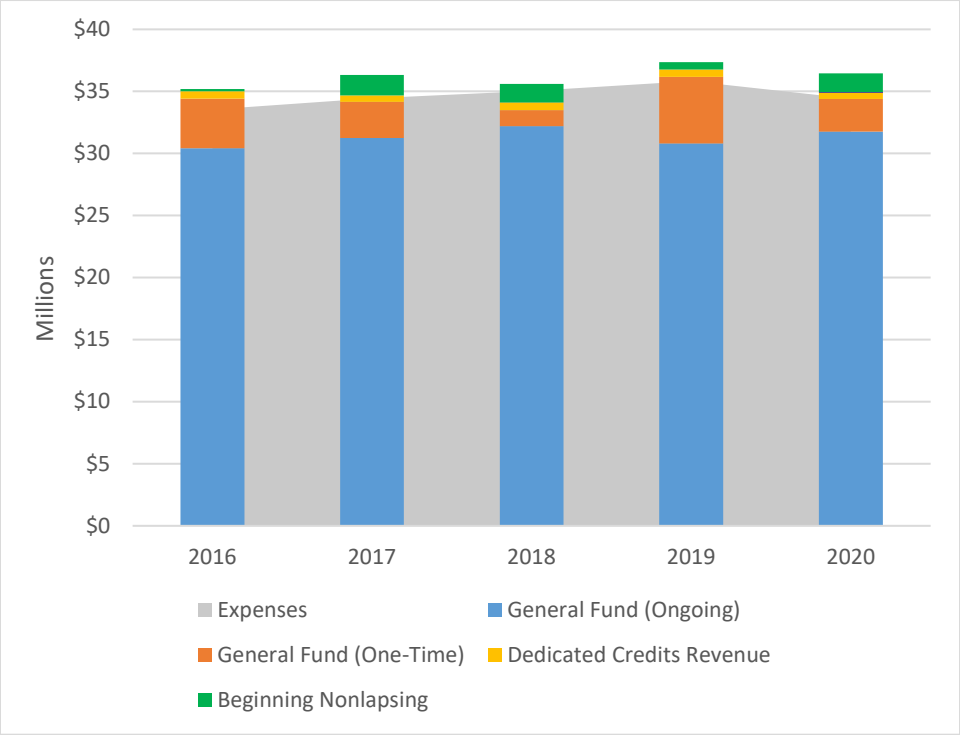
The Bureau's expenses consistently exceed ongoing appropriation revenues. Over the past five fiscal years (2016 to 2020), the Bureau's expenses averaged $34.7 million per year, while ongoing appropriations averaged $31.3 million per year. The $3.4 million

[4] Gunnison prison uses registered nurses to triage ICRs and the Draper prison uses senior registered nurses to triage ICRs.

[5] A provider refers to any medical doctor, mental health doctor, dentist, optometrist, or physician assistant.

average annual deficit[6] has largely been supplemented by one-time General Fund appropriations, dedicated credits, and nonlapsing balances, as illustrated by Figure 1.4.

Figure 1.4 The Bureau's Expenses (Gray Area) Have Consistently Exceeded Ongoing Appropriation Amounts (Blue Bars). Each year, the Bureau requests supplemental funding in the form of one-time General Fund appropriations (orange) to help close the funding gap. Additional revenue in the form of dedicated credits (yellow) and nonlapsing balances (green) also helps to address funding gaps.



Source: Division of Finance

The Bureau has received one-time General Fund appropriations (orange) for the last five years.

Figure 1.4 shows the contrast between revenues and expenses. The Bureau has been granted statutory authorization for nonlapsing funds. In other words, money[7] that is not spent at the close of a fiscal year may be carried over to the following fiscal year. It is crucial to

[6] The average annual deficit of $3.4 million equates to roughly 10 percent of the Bureau's total budget.

[7] The Utah Legislature authorizes program-specific nonlapsing fund amounts each year in the Executive Offices and Criminal Justice Base Budget Bill. For example, the nonlapsing fund amount authorized for prison medical services for fiscal year 2021 is $2.5 million. On average, the Bureau carries forward a nonlapsing fund balance of roughly 4 percent of their total budget.

understand carryover funds (nonlapsing funds) and other revenue streams, such as dedicated credits and one-time supplemental funding requests since the Bureau relies on this additional income to meet its expenditures.[8]

In 2020, the Bureau implemented our office's 2013 audit recommendation, which has resulted in significant cost savings.

According to Bureau management, budgeting for medical services is challenging because medical expenses can be unpredictable. Management stated that the Bureau asks for a supplemental appropriation annually to budget for unforeseen medical emergencies and surgeries. Regarding unforeseen medical necessities, the Bureau recognized significant costs savings in 2020 by renegotiating one of its outside medical provider contracts. We are encouraged by this action as it fulfilled a recommendation that our office gave to the department in 2013.

Statute Requires Accreditation

The Bureau is required by ***Utah Code* 64-13-39** to apply for and meet all accreditation requirements set by NCCHC, which the Gunnison prison successfully completed in 2019 and the Draper prison successfully completed in 2020. NCCHC assists correctional and detention facilities to provide effective and efficient healthcare. NCCHC has 60 standards within the following seven categories:

The Bureau is statutorily required to be compliant with National Commission for Correctional Health Care (NCCHC) standards.

- Governance and administration
- Health promotion, safety, and disease prevention
- Personnel and training
- Ancillary healthcare services
- Patient care and treatment
- Special needs and services
- Medical–legal issues

Each standard is classified as either "essential" or "important." There are 39 essential standards and 21 important standards. NCCHC accredits facilities that demonstrate 100 percent compliance to applicable essential standards and 85 percent compliance to applicable important standards. The accreditation assessment is a week-long process that occurs once every three years. The onsite assessment consists of NCCHC sending a survey team to the facility for an

[8] Budgeting practices, and the need for increased transparency in funding allocations, are discussed in detail in Chapter IV of this report.

in-person review. Afterward, the lead surveyor submits a report to NCCHC for review by the accreditation committee. To be clear, we did not audit the accreditation process and, therefore, provide no opinion on NCCHC's position. Our audit process is separate from the accreditation process and is designed to give comprehensive and thorough review of state prison healthcare operations. Our audit included more than five months of on-site interviewing, observing, analyzing, and documenting activities within the prison's Clinical Services Bureau. Both the Draper and Gunnison prison sites were evaluated independently and are identified as applicable in the report.

Audit Scope and Objectives

We were asked by the Legislature to evaluate the quality, efficiency, and effectiveness of healthcare services being administered in Utah's prison system and to determine if any medical neglect has occurred and, if so, to what degree. In addition, we were asked to review how effectively COVID-19 concerns have been addressed.

To assist with the review of inmate medical cases, we contracted with Marc Babitz, MD, to serve as a medical consultant. As part of this audit, Dr. Babitz reviewed 76 sampled medical cases and provided medical expertise. His conclusions and resume can be found in Appendix B of this report. One continuing theme throughout the course of this audit was the poor condition of the data maintained by the Bureau. Data provided by the Bureau required us to spend a significant amount of time putting the data into a usable format to determine compliance. The following chapters address risk areas and recommendations that we identified throughout the course of this audit.

To assist with the review of inmate medical cases, we contracted with Marc Babitz, MD, to serve as a medical consultant.

- **Chapter II:** Primarily discusses the need for management to improve patient monitoring, patient follow-up, continuity of care, and more effectively regulate inmates' diabetes.
- **Chapter III:** Discusses the need for management to comply with statute and standards involving the inmate intake process, ICRs, and personal health information.

- **Chapter IV:** Discusses how management can improve administrative and fiscal oversight as well as general program operations.

Chapter II
Management Needs to Improve Systemic Deficiencies within Clinical Services

Our review of the Utah state prison system's Clinical Services Bureau (Bureau, or prison medical) found several systemic deficiencies that negatively impacted patient outcomes. We found that prison medical professionals are generally dedicated employees working to provide quality care. However, systemic deficiencies, at times, threaten the level of care provided. In most cases, inmates received competent medical care. Unfortunately, in other cases, systemic deficiencies significantly delayed or degraded the level of care provided.

Systemic deficiencies, at times, threaten the level of care provided.

Our audit team spent several months working with and observing prison medical staff, interviewing staff and inmates, analyzing data, evaluating compliance, and identifying areas of improvement. To assist in our review, we consulted with a licensed physician with more than 40 years of clinical experience. Ultimately, we concluded that the primary reason for the Bureau's systemic deficiencies is inadequate oversight from multiple levels of personnel. The following bullet points summarize our findings.

The primary reason for the Bureau's systemic deficiencies is inadequate oversight from multiple levels of personnel.

Chapter II

- Several inmates were given inappropriate or inadequate care.
- Follow-up and patient monitoring are insufficient.
- Improper monitoring of diabetes presents a serious risk to some inmates.
- Oversight of prison medical regarding COVID-19 could improve.

Chapter III

- Statutorily required national accreditation standards are not consistently being met.
- A lack of oversight regarding inmate healthcare requests (ICRs) has resulted in concerns with face-to-face patient

assessments, delays in internal prioritization timelines, and ICRs not being entered into the electronic medical record (EMR) system.

- Emergency medical technicians (EMTs) do not always complete their shift requirements.[9]
- Medications are not being distributed according to statute and standards.
- Medical staff failing to protect personal health information.
- Medical staff failing to secure biohazard waste bins.

Chapter IV

- Multiple *Administrative Rule* violations regarding individual incentive award programs.
- A lack of transparency regarding funding allocations and the use of program funds.
- Program performance metrics do not reflect actual program operations.
- Policies, procedures, and training materials are outdated.

We recommend that the executive director of UDC ensure that all recommendations are adequately implemented.

Due to the nature of these findings, we recommend that the executive director of the Utah Department of Corrections (UDC) ensure that all recommendations in this audit report are adequately implemented. Our audit team worked closely with Bureau management throughout the duration of this audit. While management responded to audit requests and concerns in a timely manner, the documentation provided did not always directly address the concerns we raised or impact audit conclusions. To ensure all concerns have been sufficiently addressed, we recommend that the executive director also launch an internal review to determine if additional changes not addressed in this report are needed regarding operations and/or staff.

To ensure all concerns have been sufficiently addressed, we also recommend that the executive director launch an internal review.

[9] Each shift, EMTs are supposed to complete an inventory of all medical supplies and fill out a daily log to ensure that supplies are current and available.

Improved Practices and Oversight Are Needed to Ensure Quality Care

The lack of follow-up and patient monitoring is a systemic concern that extends beyond the COVID-19 pandemic. This conclusion is based on a medical review of 76 sampled[10] cases (independent medical issues) for 47 unique inmates. The sample consisted of a variety of medical issues and concerns that spanned a three-year period. We contracted with a physician who has more than 40 years of clinical experience as a medical provider and a public health expert. The consultant's full report can be found in Appendix B of this audit report. The consultant focused on the Draper facility; however, the review included a small number of medical cases for inmates at the Gunnison facility. Most cases reviewed by the physician showed no significant concerns (83 percent). However, the medical review revealed some substantial concerns that indicate a need to repair key areas of the deficient healthcare system in Utah prisons. The following two points summarize these concerns:

The medical review revealed some substantial concerns that indicate a need to repair key areas of the deficient healthcare system in Utah prisons.

- Inappropriate or inadequate medical care was given in 17 percent of the sampled cases (about one in every six cases).
- Lack of follow-up and patient monitoring was identified in nearly one-third of all cases.

The specific cases identified by our contracted physician are concerning and should be remedied with immediate action. That said, we do not characterize the prison healthcare system as deficient based on these cases alone. Additional clinical and administrative concerns in need of correction and repair will be demonstrated throughout this audit report.

We do not characterize the prison healthcare system as deficient based on the sample cases alone. Additional concerns will be demonstrated throughout this audit report.

[10] Sampled cases were selected to include medical cases, some COVID-19 cases (about 26 percent), and cases from inmate and other interviews. The sample was not designed to be extrapolated to the general prison population.

Several Inmates Were Given Inappropriate or Inadequate Care

In several cases, the care provided to inmates was either inappropriate or inadequate.

In several cases, the care provided to inmates was either inappropriate or inadequate. While these cases range in complexity and severity, the medical care provided in each of these cases should be improved. General examples of inappropriate or inadequate care identified in our audit process include, but are not limited to the following categories:

- Unreasonable delays and inconsistencies in critical medications.
- Administration of wrong medications.
- Resolved ICRs indicating a provider assessment had been completed when it had not been.
- Unreasonable delays in appropriate exams and treatment plans.
- Failure to follow national guidelines and internal protocols.

Prison medical staff failed to follow a treatment regimen provided by a specialist, thereby presenting concerns for the potential success of the treatment.

A specific example of a case that falls into one or more of these categories involves a critical drug treatment regimen recommended by a healthcare specialist outside[11] of the prison. In this case, the specialist provided detailed instructions on the amount, number, and frequency of medication doses over a specific time frame. We found that the treatment regimen provided by the specialist was not consistently followed by prison medical staff, thereby presenting concerns for the potential success of the treatment. The primary concern in this case (and in other cases with documented occurrences of inconsistent and inadequate treatment) is the level of substandard care. Inadequate care such as this could negatively impact patient health outcomes and incur additional healthcare-related expenses.

[11] Outside care is any healthcare provided by someone other than department staff. This includes all appointments, surgeries, tests, X-rays, etc. that are conducted at outside healthcare clinics and hospitals. Additionally, telemedicine is available in the Wasatch Infirmary at the Draper prison site, where a camera and a telephone connection are used to provide live video conferencing with specialists, who are able to see and converse with inmates.

National Accreditation Standards Require Inmates to Receive the Care That Is Ordered. The National Commission on Correctional Health Care (NCCHC) has 39 essential standards that require 100 percent compliance to achieve accreditation. Utah statute requires UDC to comply with NCCHC standards. The first essential standard defines access to care as follows:

Utah statute requires UDC to comply with NCCHC standards.

> Access to care means that, in a timely manner, a patient is seen by a qualified health care professional, is rendered a clinical judgment, and receives care that is ordered.[12]

This standard requires the responsible health authority to identify and eliminate any unreasonable barriers, intentional or unintentional, to inmates receiving healthcare. The standard also provides examples of unreasonable barriers, such as having an understaffed, underfunded, or poorly organized system, resulting in the inability to provide appropriate and timely access to care. ***Utah Code***[13] requires UDC to comply with NCCHC standards. NCCHC is also required to conduct inspections to ensure compliance and accreditation. According to NCCHC, the on-site survey cycle (inspection) occurs approximately every three years and typically lasts about a week, depending on facility size and complexity. Accreditation is a useful tool that provides needed feedback. However, the purpose of our audit work is not accreditation; rather, our audit is intended to provide management with a comprehensive review of where deficiencies exist, so that improvements and adjustments can be made. Our audit team spent several months working with and observing medical services, interviewing clinical staff and inmates, analyzing data, evaluating compliance, and identifying areas of improvement.

The purpose of our audit work is not accreditation; rather, our audit is intended to provide management with a comprehensive review of where deficiencies exist.

Lack of Follow-Up and Patient Monitoring Is Problematic

Insufficient documentation on individual medical charts made evaluating the quality of care increasingly difficult. For example, 30 percent of medical charts (23 cases) reviewed by our medical consultant were lacking sufficient information. Of the 23 cases, only 6 were COVID-19 cases. The other 17 cases detailed medical concerns and chronic conditions such as cancer, stroke, acute injury, and

[12] NCCHC P-A-01.
[13] ***Utah Code 64-13-39.***

Several patients did not receive adequate and timely follow-up visits or appropriate patient monitoring.

medication requests. In many instances, the medical provider would request "monitoring," or "increased monitoring," however, these orders did not contain specific parameters such as the frequency of the checks or the type of checks (e.g., vital signs, oxygen saturation levels, etc.). As a result, several patients did not receive adequate and timely follow-up visits or appropriate patient monitoring.

The lack of follow-up and patient monitoring became especially concerning throughout the COVID-19 pandemic, which overwhelmed—as was the case in most healthcare facilities—the prison's medical system. The increased workload imposed upon clinical staff by the pandemic resulted in insufficient numbers of medical staff to maintain a high quality of clinical care for all patients, and especially for COVID-19 patients. According to our medical consultant:

> Patients who test positive [for COVID-19] and are high risk need to be closely monitored, at a minimum, daily checking of their vital signs, especially their temperature and their oxygen saturation. When there is any evidence of a patient's condition worsening, those checks should occur more frequently, e.g. 2–4 times/day.

Provider orders for patients diagnosed with COVID-19 were vague and did not stipulate specific parameters of care.

For several inmates who were diagnosed with COVID-19, the provider requested "monitoring," or "increasing monitoring," but the orders were vague and did not stipulate specific parameters of care.

The Lack of Follow-Up and Patient Monitoring Appears to Be Systemic and Extends Beyond the COVID-19 Pandemic. During the pandemic, medical staff adopted a record-keeping practice for COVID-19 patients known as "charting by exception." Charting by exception streamlines the documentation process by reducing or eliminating redundant charting. In some of the COVID-19 specific cases, care was reportedly given for which no documentation exists. That said, only 26 percent of the sampled cases reviewed by our medical consultant were related to the COVID-19 pandemic.

Of the 76 cases reviewed by the medical consultant, 23 cases[14] (30 percent) were not seen in the correct amount of time, based on the

[14] The 23 cases date back to 2018; only six of these cases were COVID-19 cases.

medical issue in question.[15] In other cases, resolved ICRs indicated that a provider assessment had been completed when it had not been. To verify this, we reviewed patient medical charts and did not find provider assessments in the corresponding medical charts. Furthermore, we observed an EMT administering the wrong medication to an inmate. Although the incident was reported, there was no evidence of prison medical staff conducting follow-up visits or increased patient monitoring. The lack of follow-up and patient monitoring is a contributing factor to the larger issues of inappropriate and inadequate care.

Resolved ICRs indicated that a provider assessment had been completed when it had not been. To verify this, we reviewed patient medical charts and did not find provider assessments in the corresponding medical charts. Furthermore, we observed an EMT administering the wrong medication to an inmate.

Prison Medical Needs to Effectively Regulate Inmates with Diabetes

Another factor leading to our conclusion that the prison medical system is deficient is the problematic care of inmates with diabetes. Between 8 and 9 percent of inmates at both prison locations have diabetes.[16] According to the American Diabetes Association (ADA), inmates with diabetes should be closely monitored. However, we question whether current practices meet the ADA's standard of measuring blood sugar (glucose) levels three or more times daily. Our conclusion is based on the following:

- Blood sugar levels are not sufficiently monitored at all levels of prison security.
- After receiving insulin, inmates do not always receive food within the recommended time frames.

At the Draper prison, the amount of time between insulin distribution and mealtime does not follow internal protocols or meet the ADA's recommended timelines. Significant deviations from ADA guidelines could result in inmates developing complications and long-term damage. Conversely, regular monitoring of blood glucose levels could mitigate further complications.

At Utah prisons, the amount of time between insulin distribution and mealtime does not follow internal protocols or meet ADA guidelines.

[15] The response timeline and handling of ICRs are discussed in detail in Chapter III.
[16] As of October 2021, the number of inmates diagnosed with diabetes included 132 inmates at the Gunnison prison site (7.8 percent) and 226 inmates at the Draper prison site (8.6 percent).

Increased Monitoring of Blood Sugar Levels Is Needed at All Levels of Prison Security

We observed instances of dangerously low and dangerously high blood sugar readings, which likely could have been mitigated through increased monitoring and proper treatment.

We observed instances of dangerously low and dangerously high blood sugar readings, which likely could have been mitigated through increased monitoring and proper treatment by medical staff. Although most diabetic inmates reportedly have a glucometer to help them self-monitor their blood sugar levels, not all inmates are able to self-monitor due to behavioral and/or custody concerns. ADA guidelines for diabetes management in correctional institutions state, "Patients at all levels of custody should have access to medication at dosing frequencies that are consistent with their treatment plan and medical direction." While diabetic inmates have an individual responsibility for self-management (such as adhering to recommended diets), new intakes and inmates with behavioral concerns are largely dependent on prison medical staff for care. Without a glucometer to self-monitor or access to food beyond routine meals,[17] we are concerned that some diabetic inmates are not receiving adequate monitoring or proper treatment. For example, we observed a blood sugar reading of 59 mg/dl[18] at 10:26 pm for a new intake who was not approved for food beyond scheduled mealtimes.

Without a glucometer to self-monitor or access to food beyond routine meals, we are concerned that some diabetic inmates are not receiving adequate monitoring or proper treatment.

Failing to maintain a healthy blood sugar level results in complications such as hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Severe hypoglycemia is a medical emergency and may include confusion, incoherence, combativeness, somnolence, lethargy, seizures, and coma. Hyperglycemia weakens blood vessels and can affect fingers, toes, skin, eyes, kidneys, and the heart. Our review of patient medical charts revealed a diabetic inmate who experienced multiple episodes of hypoglycemia within a six-week period.

The ADA states that patients with type 1 diabetes are at risk for hypoglycemia and should have their blood glucose levels monitored three or more times daily. Currently, medical staff at the Draper prison site monitor blood glucose levels of diabetic inmates twice daily

[17] Additional food options such as prison commissary and PM boxes will be discussed in a later section.

[18] A normal blood glucose level is defined by the ADA as greater than 70 mg/dl.

during pill line.[19] The Gunnison prison site likewise provides access to insulin twice daily. A potential solution to increase patient monitoring and more closely evaluate inmate diabetes management regimens may include adding a third pill line.

If Bureau management opts to transition from two to three pill lines daily, that practice would match what is being done in other prison healthcare systems. For example, surrounding states including Colorado, Arizona, Idaho, and Montana all operate pill lines three times daily. While there may be a variety of reasons these states chose to operate pill lines three times daily, a third pill line in Utah prisons would increase access to care and may also prove beneficial to inmates whose prescribed medications are intended to be taken closer to bedtime. A third pill line is just one option; the method of ensuring that diabetic inmates are properly monitored ultimately lies with Bureau management.

The method of ensuring that diabetic inmates are properly monitored ultimately lies with Bureau management.

After Receiving Insulin, Inmates Do Not Always Receive Food within Recommended Time Frames

Our audit team identified three concerns related to insulin routines not being appropriately timed with meals:

- The amount of time between insulin distribution and meals does not always follow internal protocols or meet ADA standards.
- Diabetic protocols are outdated and do not specify how to manage disruptions or delays to the normal schedule.
- Significant delays in provider treatment orders and renewals further complicate diabetic management.

As noted earlier in this chapter, the statutorily enforced NCCHC standards require inmates to have access to care in a timely manner

NCCHC standards require inmates to have access to care in a timely manner and to receive the care that is ordered.

[19] The Bureau operates a pharmacy to provide prescription medications to inmates. Depending on the type of medication, inmates may receive a "blister pack" of pills that they can self-administer. Pill lines are held twice daily for medications that must be more carefully monitored. In addition to the twice daily pill lines, one location at the Draper prison site holds two more pill lines for critical cases including diabetic inmates.

and to receive the care that is ordered. The following section addresses each of these three concerns in detail.

Significant deviations from the 30-minute standard could result in complications such as hypoglycemia and hyperglycemia.

The Amount of Time Between Insulin Distribution and Mealtime Does Not Always Follow Internal Protocols or Meet ADA Standards. The ADA states that regular insulin[20] works best if taken 30 minutes before eating. Similarly, prison medical staff are trained to make sure that diabetic inmates are fed within 30 minutes of receiving regular insulin. Significant deviations from the 30-minute standard could result in complications such as hypoglycemia and hyperglycemia.[21] At several locations throughout the Draper prison site, our audit team observed that the amount of time between insulin distribution and mealtimes exceeded the 30-minute standard.

Figure 2.1 The Amount of Time Between Insulin Distribution and Mealtime Exceeds the 30-Minute Standard. The data in this figure represent seven unique instances where diabetic inmates waited longer than 30 minutes for their meal. Significant deviations from the 30-minute standard could result in serious complications for diabetic inmates.

Location	Insulin Type	Duration between Insulin and Meal
Housing Unit A	Regular	**64 mins**
Housing Unit B	Rapid*	**67 mins**
Housing Unit B	Regular	**92+ mins**
Housing Unit C	Rapid*	**50 mins**
Housing Unit D	Regular	**92 mins**
Housing Unit E	Regular	**72 mins**
Housing Unit F	Regular	**73 mins**

Source: Auditor observations
** Rapid insulin, or fast-acting insulin, has a quicker onset than regular insulin.*

[20] Regular, or short-acting insulin usually reaches the bloodstream within 30 minutes after injection, peaks anywhere from two to three hours after injection, and is effective for approximately three to six hours. Types of regular insulin include Human Regular (Humulin R, Novolin R, and Velosulin R).
[21] The previous section details some of the complications associated with low and high blood sugar levels.

Moreover, our audit team analyzed officer logs[22] from three different housing units at the Draper prison location over a four-month period, from May to August 2021.[23] Using the daily log data, we created a separate document combining all pill line and mealtime observations. Once all observations were in one collective location, we analyzed the time intervals between each pill line and meal delivery. The analysis of the three Draper housing units revealed that the 30-minute standard was met only 7 to 27 percent of the time. Data from the officer logs suggest that one Draper housing unit failed to provide food within the 30-minute standard 93 percent of the time.

Data from the officer logs suggest that one Draper housing unit failed to provide food within the 30-minute standard 93 percent of the time.

Related to the extended delays between insulin distribution and mealtimes, inmates have reportedly skipped taking insulin when it is offered so far from mealtime. To address this issue, we recommend that the Bureau follow ADA guidelines and internal protocols by ensuring that insulin is administered 30 minutes before mealtimes. Although this recommendation addresses some timeline concerns, other diabetic chronic care management issues also exist.

Prison Protocols Are Outdated and Do Not Specify How to Manage Disruptions or Delays to the Normal Schedule. While we recognize the timing of insulin and meals can be complicated within a prison setting where "lock downs" and other disruptions occur, correctional institutions should have response protocols in place as part of the patient's medical plan. An ADA publication[24] addressing diabetes management in correctional settings states:

> Should circumstances arise that delay patient access to regular meals following medication administration, policies and procedures must be implemented to ensure the patient receives appropriate nutrition to prevent hypoglycemia.

[22] Officer logs are daily records kept by custody staff. The logs should include all movements, security checks, counts, case numbers of incidents, visitors on unit, and any activity deemed appropriate to note. Our audit team used these logs to record pill line and mealtime observations.

[23] Officer logs from the Gunnison prison location were missing essential data, rendering them unusable for audit purposes.

[24] American Diabetes Association. "Diabetes Management in Correctional Institutions." *Diabetes Care,* vol. 31, Supplement 1, Jan. 2008, pp. S90.

Although the Bureau has protocols in place for the identification and management of chronic diseases such as diabetes, the protocols do not specify how to manage disruptions to the normal schedule.

Inmates who do not have access to food items through prison commissary are entirely dependent on prison mealtimes for food.

Because treatment orders expire after one year, and renewals are not always timely, diabetic inmates may go weeks without receiving the necessary food to help regulate their blood sugar levels.

Significant Delays in Provider Treatment Orders and Renewals Further Complicate Diabetic Management. Provider treatment orders are good for one year only and need to be renewed annually; however, our audit team identified multiple instances of diabetic inmates going weeks without a treatment order renewal and, therefore, without the necessary food for their individual diabetes management. New intakes and inmates with behavioral concerns may not have access to food items through prison commissary,[25] which is considered a privilege based on behavior. Therefore, inmates who do not have access to food items through prison commissary are entirely dependent on prison mealtimes for food. Aside from the basic three meals per day, the prison offers a "PM box," which is reserved solely for inmates who qualify. A PM box includes additional food items to help diabetic inmates regulate their blood sugar levels throughout the night. To qualify for a PM box, an inmate must receive a treatment order from a provider. However, because treatment orders expire after one year, and renewals are not always timely, diabetic inmates may go weeks without receiving a PM box to help regulate their blood sugar levels.

Oversight of Prison Medical Regarding COVID-19 Could Improve

Many lessons have been learned and will continue to be learned during the COVID-19 pandemic. As discussed previously in this chapter, we are concerned with the lack of follow-up and patient monitoring regarding inmates. Specifically, the lack of documentation for inmates who contracted COVID-19 is concerning. Insufficient information on individual medical charts made evaluating the level of care increasingly difficult. In several of the COVID-19 cases, care was reportedly given for which no documentation exists. Furthermore, we observed personal protective equipment (PPE) regarding COVID-19 test procedures failing to meet CDC standards. These are examples

[25] Commissary offers products for sale such as packaged food items, writing materials, electronics, additional hygiene products, arts and craft supplies, and approved clothing items.

where systemic deficiencies caused by poor oversight may have negatively impacted the care of inmates.

Lastly, we reviewed other aspects of the COVID-19 response and found that quarantine data from the Draper prison site were poorly organized and incomplete. Therefore, our audit team was not able to draw any conclusions as to whether appropriate quarantine guidelines were followed.

Systemic deficiencies caused by poor oversight may have negatively impacted the care of some inmates.

Recommendations

1. We recommend that the executive director of the Utah Department of Corrections ensure that all recommendations in this audit are adequately implemented.

2. We also recommend that the executive director of the Utah Department of Corrections launch an internal review to determine if additional changes not addressed in this report are needed regarding operations and/or staff.

3. We recommend that the Clinical Services Bureau ensure that providers and other medical staff define the term "monitor" in patient charts with specific parameters on a case-by-case basis.

4. We recommend that the Clinical Services Bureau increase oversight to ensure that appropriate case-by-case patient follow-up procedures are being completed.

5. We recommend that the Clinical Services Bureau ensure that all patients have access to:

    a. Appropriate and timely clinical judgments rendered by a qualified healthcare professional.

    b. Correct treatments and medications for corresponding diagnoses.

6. We recommend that the Clinical Services Bureau follow internal policies and professionally recognized standards regarding the administration of insulin and the oversight of inmates with diabetes.

7. We recommend that the Clinical Services Bureau create policies and procedures to effectively manage nutrition and medical care for diabetic patients during disruptions or delays to the normal schedule.

8. We recommend that the Clinical Services Bureau develop policies, where appropriate, that help the organization be more compliant with CDC standards regarding medical issues such as the COVID-19 pandemic.

Chapter III
Management Can Improve Its Compliance With Statute and Standards

As addressed in Chapter II of this report, the Utah Department of Corrections (UDC) prison healthcare system needs improvement. In this chapter, we address several areas of concern and provide recommendations for improvement. The National Commission for Correctional Health Care (NCCHC) is the official accreditation body for UDC. Per statute, the Clinical Services Bureau (Bureau, or prison medical) must follow NCCHC standards to achieve accreditation, which was successfully accomplished in 2020.

Our audit report is not intended to supersede NCCHC conclusions or act as an accreditation review. Rather, our review is intended to help executive leadership at UDC ensure that the Bureau is functioning in an efficient and effective manner. In this chapter, we report on four areas in need of improvement. The first two address the Bureau's inconsistency in adhering to NCCHC standards and the use of emergency medical technicians (EMTs) in situations beyond their training and skill level. The last two areas describe how the Bureau needs to follow state statute and standards. More specifically:

This audit is intended to help executive leadership at UDC ensure that the Bureau is functioning in an efficient and effective manner.

- We observed and documented seven NCCHC standards that are not consistently followed.
- Bureau management is using EMTs in situations that they have not been adequately trained for. For example, EMTs are delivering medication at pill lines and are assessing routine healthcare requests. We question whether the use of EMTs in a nonemergency setting places them in situations beyond their limited clinical training and education, which is focused on medical emergencies.
- Personal health information is not adequately protected per state statute and national standards. We found inmates' personal health information in public dumpsters outside the prison.

We found that the Bureau is not consistently complying with NCCHC standards.

- The Bureau is not following the inmate handbook fee schedule. We found 165 copay charges assessed to inmates for mental health services from fiscal year 2018 to 2021. These copays for mental health services are not in line with the inmate handbook.

Management Should Ensure That Statutorily Required Standards Are Followed

Bureau management needs to improve its oversight and supervision to ensure that proper medical care is provided to inmates. We documented and observed that the Bureau is not consistently meeting statutorily required standards. Again, our audit work is not intended as an accreditation review, which usually occurs in a week or less. Rather, our review is a performance and compliance review consisting of several months of direct, on-site work. In Chapter II, we conclude that the prison healthcare system is deficient, and that the primary reason for systemic deficiencies is inadequate oversight from multiple levels of personnel.

Systemic deficiencies in prison healthcare are due to inadequate oversight from multiple levels of personnel.

In addition to the standard on access to timely healthcare discussed in Chapter II, our in-depth audit identified seven essential standards that we believe are deficient and in need of immediate correction. Prior to introducing the essential standards and corresponding deficiencies, it is important to note that the datasets provided to us were poorly kept, thereby limiting our analysis. That said, we were able to document a lack of compliance to essential standards by analyzing the remaining usable data. The following list summarizes our findings:

- **Standard:** NCCHC Essential Standard: P-E-04(1): All inmates receive an initial health assessment as soon as possible, but no later than seven calendar days after admission. **Documented Deficiency:** We found that over a three-year period, 180 inmates did not receive their health assessment within the seven-day standard. We documented this deficiency by analyzing inmate intake and refusal data. Additional details are found on pages 26–28.

The initial health assessment standard that requires inmates to be seen within seven days is not always being met.

- **Standard:** NCCHC Essential Standard: P-E-05(6): Mental health evaluations of patients with positive screens should be completed within 30 days, or sooner if clinically indicated. **Documented Deficiency:** Over a three-year period, 3 qualifying male inmates at the Draper prison site did not receive a mental health evaluation within the 30-day standard. Furthermore, we were not able to verify mental health evaluations for 143 inmates due to poor record keeping. Over a two-year period, 15 qualifying female inmates at the Draper prison site did not receive an evaluation within the 30-day standard. Gunnison did not provide the requested data. We documented this deficiency by analyzing mental health intake and refusal data for male and female inmates. Additional details are found on pages 26–28.

The mental health evaluation standard that requires inmates to be seen within thirty days is not always being met.

- **Standard:** NCCHC Essential Standard: P-E-06(6): An oral examination is performed by a dentist within 30 days of admission. **Documented Deficiency:** Over a three-year period, 277 male inmates and 31 female inmates (308 total cases) at the Draper prison site did not receive an oral examination within the 30-day standard. It is important to note that 301 of these cases were identified as noncompliant during calendar year 2020. While we recognize that the COVID-19 pandemic affected clinical operations, 7 cases were identified as noncompliant prior to 2020. The Gunnison prison site did not provide the requested data. We documented this deficiency by analyzing dental intake and refusal data for male and female inmates. Additional details are found on pages 26–28.

- **Standard:** NCCHC Essential Standard: P-E-07(4): A face-to-face encounter for a healthcare request is conducted by a qualified healthcare professional, or the healthcare liaison (if applicable), within 24 hours of receipt by health staff. **Documented Deficiency:** This is not always occurring at the Draper prison site; however, face-to-face encounters are occurring at the Gunnison prison site. We documented this deficiency by observing

20 pill lines over a five-week period. Additional details are found on pages 28–29.

- **Standard:** NCCHC Essential Standard: P-C-05(2): Staff administering or delivering prescription medication should be trained in common side effects. **Documented Deficiency:** We are concerned that EMTs in the prisons are delivering medications beyond their level of training and lack the proper training with regard to medication side effects. We observed several examples of this occurring. This is discussed in more detail on pages 32–34.

Personal health information is not being protected as required by NCCHC standards.

- **Standard:** NCCHC Essential Standard: P-A-08(7): Access to health records and health information is controlled by the responsible health authority. **Documented Deficiency:** We found personal health information in public dumpsters outside the prison. This is discussed in more detail on pages 34–37.

- **Standard:** NCCHC Essential Standard: P-D-01(3): The facility maintains records as necessary to ensure adequate control and accountability for all medications, except those that may be purchased over the counter. **Documented Deficiency:** We found medications that should have been retained and returned to the pharmacy in public dumpsters outside the prison. This is discussed in more detail on pages 34–37.

While this audit is not an accreditation review, it is a performance audit that is meant to be a tool to help executive leadership at UDC ensure that the Bureau is functioning in an efficient and effective manner.

Initial Health Assessment Timelines Do Not Meet NCCHC Standards

Bureau management needs to improve its oversight to ensure that initial health assessments are being performed as required by NCCHC standards.

Bureau management needs to improve its oversight to ensure that initial health assessments are being performed as required by NCCHC standards. The following essential standards focus on the intake process of new inmates entering the prison:

- **Standard:** P-E-04(2): All inmates receive an initial health (medical) assessment as soon as possible, but no later than seven calendar days after admission.
- **Standard:** P-E-05(6): Mental health evaluations of patients with positive screens are completed within 30 days, or sooner if clinically indicated.
- **Standard:** P-E-06(6): An oral examination is performed by a dentist within 30 days of admission.

Intake assessments are important because medical personnel need to identify the inmate's medical, mental health, and dental needs and establish a plan for meeting those needs.

Bureau Management Needs to Improve Health Intake Assessments of Inmates. From 2018 to 2020, we found that 180 inmates did not receive an initial health (medical) assessment within the seven-day NCCHC time frame. Of the 180 inmates, 34 waited longer than one month for their assessment, with the longest wait time recorded at 307 days. We documented this deficiency by analyzing three years (2018 to 2020) of data containing inmate intake history. We also found that intake records have been poorly maintained. For example, during the same time frame, 348 inmates had no recorded assessment dates and no recorded refusals.

Bureau Management Needs to Improve Mental Health and Dental Intake Assessments to Comply with NCCHC Essential Standards. A mental health evaluation is to be completed within 30 days if a new inmate answers "yes" to any critical questions during the mental health screening. Between calendar years 2018 and 2020, a total of 3 qualifying male inmates at the Draper prison site did not receive a mental health evaluation within the 30-day standard. We documented this deficiency by analyzing three years (2018 to 2020) of mental health intake and refusal data. We also found that the records have been poorly maintained. For example, during the same time frame (2018 to 2020) we were not able to determine whether 143 inmates received a mental health evaluation. In several other instances, there was no recorded evaluation date even though the data indicated that an evaluation was either scheduled or completed. Between

Compliance with mental health and dental intake assessment standards needs to improve.

calendar years 2019 and 2020,[26] a total of 15 qualifying female inmates at the Draper prison site did not receive a mental health evaluation within the 30-day time frame.

Similarly, oral exams are to be completed by a dentist within the first 30 days of intake. Between calendar years 2018 and 2020, a total of 277 male inmates and 31 female inmates at the Draper prison site did not receive an oral exam within the 30-day timeline. We documented this deficiency by analyzing three years (2018 to 2020) of dental intake and refusal data for male and female inmates.

A pattern of noncompliance was identified before the COVID-19 pandemic.

While we recognize that the COVID-19 pandemic affected clinical operations in calendar year 2020, a pattern of noncompliance was identified that occurred before the pandemic. Therefore, we recommend that Bureau management ensure that all inmates receive their mandatory intake assessments within the time frames required by NCCHC standards. Management should also ensure that all intake assessment data are accurately recorded and appropriately maintained.

Oversight of Inmate Healthcare Requests Needs to Be Improved

Bureau management needs to improve its oversight to ensure that inmate healthcare requests (ICRs) are handled appropriately and within a timely manner. According to NCCHC standards, once an ICR is submitted and collected, medical staff are required to have a face-to-face encounter with the inmate who submitted the ICR within 24 hours. However, we found that face-to-face encounters are not always occurring at the Draper prison site. Additionally, the internal goal of seeing inmates within 15 days of ICR submission is also not occurring. We observed that the schedulers at the Draper prison site do not use the ICR triage date (prioritization date), but instead schedule appointments according to the oldest submission date.

Medical staff at the Draper prison site are not always conducting face-to-face encounters as required by NCCHC standards.

NCCHC Standards Require a Face-to-Face Encounter After ICRs Are Submitted. According to NCCHC standard P-E-07(4), a face-to-face encounter for a healthcare request is conducted by a qualified healthcare professional, or the healthcare liaison (if applicable), within 24 hours of receipt by health staff. This is not always happening at the Draper prison site. We documented this

[26] 2018 mental health assessment data for females at the Draper prison site were not available. The Gunnison prison site did not provide the requested data.

deficiency by observing 20 different pill lines over a five-week period, both in the morning and in the afternoon. In most instances, we did not see EMTs conducting face-to-face encounters for ICR submissions.

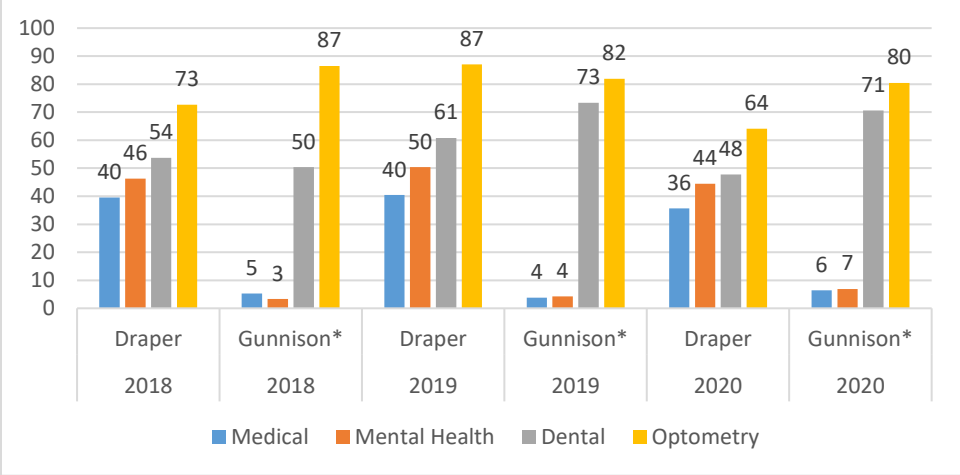
At the Draper facility, we observed multiple instances of ICRs being collected without a face-to-face encounter. For example, a mental health ICR was submitted by an inmate requesting to see a mental health provider, but no follow-up questions were asked by the EMT receiving the ICR. In contrast, at the Gunnison facility, we observed nurses collect ICRs and personally contact each inmate with an ICR submission to directly assess their concern(s). We recommend that Bureau management ensure that both state prison facilities conduct (or continue to conduct) a face-to-face encounter within 24 hours of ICR receipt by health staff.

Inmates Are Not Being Seen by Providers within the Targeted Timeline. After ICRs are entered into the electronic medical record (EMR) system, nurses[27] triage (prioritize) all ICRs, with the exception of mental health ICRs, which are triaged by mental health supervisors. According to Bureau management, nurses at the Draper facility assign each ICR a triage value between 1 and 15 days.[28] For example, a triage value of 1 means that the inmate should be seen within one day. With 15 as the maximum triage value, all inmates should be seen within 15 days. In contrast, Gunnison uses triage values of 1, 2, and 3. In this case, a triage value of 1 means the inmate should be seen within one day; 2 within seven days, and 3 within 15 days. Figure 3.1 shows the percentage of ICRs that failed to meet the specified triaged time frame, resulting in inmates having to wait longer than expected for clinical services.

[27] Gunnison prison uses registered nurses to triage ICRs and the Draper prison uses senior registered nurses to triage ICRs.

[28] The ICR forms used by inmates to submit healthcare requests, state that appointments will be scheduled within 21 days or less, unless medically urgent. Despite the inconsistency between what is stated on the ICR form and the internal timeline, the Bureau is held accountable to the 15-day timeline because of its triage process.

Figure 3.1 Triage Timelines Are Not Being Met at the Draper or Gunnison Prison Sites. In this chart, any percentage greater than zero means that the triage time frame is not being met. For example, in calendar year 2020, the Draper facility failed to meet the assigned triage date 36 percent of the time for medical requests.



Source: Auditor analysis
** Roughly 35 percent of Gunnison prison site data were not useable due to poor data entry.*

Gunnison prison does a better job of meeting medical and mental health ICR triage timelines than the Draper prison.

Those Responsible for Scheduling Appointments at the Draper Prison Site Are Not Using the Triage Value. After an ICR is triaged by a nurse, a scheduler (the person in charge of scheduling appointments) retrieves the ICR report from the EMR system. While observing medical and mental health schedulers at the Draper prison site, we noticed that they did not use the internal triage values when assigning appointment dates. Rather, schedulers prioritized ICRs according to the oldest recorded submission date. This means that an ICR submitted two weeks prior could take precedence over an emergent ICR triaged to be seen within one day. Schedulers follow this practice unless they are contacted directly by clinical staff specifically asking that a particular ICR be scheduled sooner. Besides causing potential delays for inmates in need of medical services, this practice also negates the efforts of senior nurses who spend time triaging the ICRs. By contrast, schedulers at the Gunnison prison site use internal triage values to schedule medical and mental health appointments for inmates. To prioritize patient care more effectively, we recommend that Bureau management ensure schedulers are using internal triage information when scheduling appointments for healthcare providers.

Schedulers are not using the triage value when scheduling appointments for inmates.

Not All ICRs Are Entered into the Electronic Medical Record System. Every collected ICR is supposed to be entered in the prison's EMR system, word for word, within 24 hours of receipt. After ICRs are entered into the system, medical staff commonly discard the paper ICR forms in secure shred bins. To gauge whether staff were entering ICRs into the EMR system, we collected the contents of shred bins from three different medical rooms within in the Draper prison facility. We found a total of 18 ICRs that had not been entered into the prison's EMR system. In addition, we found ten ICRs, from two different locations, that were only partially entered in the EMR system. We recommend that Bureau management train and supervise medical personnel to ensure that all ICRs are correctly entered into the EMR system in their entirety.

All ICRs are to be entered into the EMR system within 24 hrs of receipt. We found 18 discarded ICRs that had not been entered and 10 discarded ICRs that were only partially entered.

EMTs Are Not Completing Shift Requirements

EMTs are responsible for ensuring that medical rooms are stocked with proper medical supplies. There are several medical rooms throughout the prison that service corresponding inmate housing units. Therefore, each medical room should be stocked with the necessary medical supplies for immediate use in an emergency. Each shift, EMTs are supposed to complete an inventory of all medical supplies and fill out a daily log to ensure supplies are current and available. The following items are to be checked daily:

- Refrigerator temperatures
- Jump bags[29] and seal numbers[30]
- Oxygen tank pressure levels
- O2 masks, oral airways, and cannulas[31]
- Insulin medications
- Glucometers (every Sunday)
- Personal protective equipment

[29] A jump bag, or "jump kit," is the primary trauma bag carried by EMTs and paramedics. It contains a basic set of emergency supplies and other items.
[30] One of the pockets on the jump bag is to be sealed or secured with a zip tie because it holds syringes and other sharp equipment.
[31] Cannulas are used to drain fluid, administer medication, and provide oxygen.

EMTs are not consistently completing required daily inventories of medical equipment, which could be disastrous in the event of an emergency.

Inventory logs are located in each of the medical rooms and should be filled out daily. At the Draper prison site, we found multiple incomplete logs in multiple medical rooms, dating as far back as January 2021. Furthermore, we found several jump bags that were missing secure seal tags. These findings are concerning, since a lack of properly maintained medical supplies could be disastrous in the event of an emergency. One EMT we spoke with during the audit said that they bring their own personal bag and keep medical supplies from the medical room in it, because they do not trust that vital medical supplies will be available at the facility when needed. We recommend that Bureau management train and supervise EMTs to ensure that medical rooms are always stocked with the required medical supplies and that daily logs are consistently filled out.

Management Needs to Ensure Medications Are Distributed According to Statute and Standards

We have concerns with using EMTs in a nonemergency setting. Our medical consultant, who is also the former division director of Family Health and Preparedness[32] at the Utah Department of Health, reported:

> They [EMTs] do not have patient assessment education and training beyond emergency situations. Since the vast majority of medical concerns from the inmates do not involve the medical emergencies for which EMTs are trained, they are not appropriately suited to correctly evaluate these inmates and their medical concerns.

We have concerns that EMTs are being used in nonemergent situations that may be beyond their level of training.

The consultant's full review can be found in Appendix B of this report. EMTs have limited clinical training, which focuses heavily on medical emergencies.

According to the EMS Personnel Licensure Interstate Compact, which is codified in ***Utah Code 26-8c-102***, an EMT is an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National Emergency Medical Services

[32] As division director, our medical consultant oversaw EMT certification and training requirements.

(EMS) Education Standards. Figure 3.2 further explains the National EMS Education Standards concerning EMTs.

Figure 3.2 Using EMTs to Deliver Medication at Pill Lines and Perform Face-to-Face Patient Assessments Appears to Exceed National EMS Education Standards. EMT certification allows EMTs to operate in an emergency setting. We question whether regularly delivering medication and conducting nonemergent patient assessments are within an EMTs' scope of practice and level of training.

According to the National EMS Education Standards:

"The primary focus of the Emergency Medical Technician is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system."

Source: National EMS Education Standards

Based on our review of the Emergency Medical Services Licensure Interstate Compact (statute) and the National EMS Education Standards, we are concerned that the Draper prison facility might be using EMTs in situations beyond their knowledge and training capabilities. Our medical consultant agrees. His remarks are found in Appendix B.

During our interviews and observations at the prisons, an EMT shared with us that they do not feel adequately trained for some of the tasks they are asked to perform. For example, the EMT identified delivering medications at pill lines as a specific task that they feel is beyond their level of training and scope of practice. We suggest that the Bureau review its use of EMTs to ensure that they are being used according to their level of training and scope of practice. In situations that require the proper dispensing of medications, such as pill lines, nurses have the education and training to know about medication side effects (or adverse reactions) and are qualified to conduct patient assessments.

The Bureau needs to review its use of EMTs to ensure they are being used according to their level of training.

In January 2020, NCCHC's review of the Draper prison facility expressed concerns that medical staff who administer and deliver prescription medications were not being trained on the administration of retained medications or the side effects of medications. The Bureau responded to NCCHC by stating that all registered nurses (RNs) and

licensed practical nurses (LPNs) at the prison facility had received this training as part of their orientation and annually at Nursing Skills Day. We are concerned with the Bureau's response because, at the Draper prison, EMTs primarily operate pill lines, not RNs or LPNs.

We found that Colorado, Montana, and Wyoming all use nurses to administer pills lines and conduct face-to-face assessments.

We found that prisons in Colorado, Montana, and Wyoming all use nurses to administer pill lines and conduct face-to-face assessments with inmates regarding their ICRs. Likewise, the Gunnison prison primarily uses nurses to administer pill lines and conduct face-to-face assessments. While we understand that the Bureau has had a difficult time recruiting and retaining nurses at the Draper facility, management needs to be proactive in addressing this problem. One solution could be for the Bureau to implement an education loan repayment program for nurses. This program could be used to help improve recruiting and retention efforts for nurse positions.

We recommend that the Clinical Services Bureau ensure that the use of EMTs in the prison setting is consistent with state statute and best practices, and that licensed nurses (or other qualified medical professionals) are used in situations that require a level of skill and knowledge beyond what an EMT is certified for.

Management Needs to Better Protect Personal Health Information

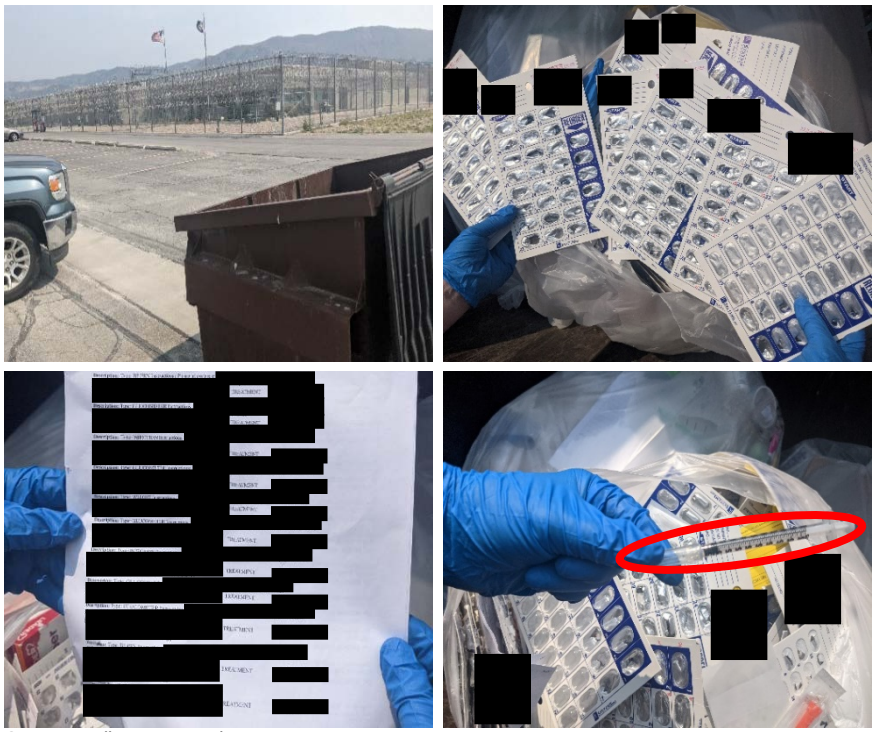
Management needs to improve the protection of inmates' personal health information. Additionally, management should ensure that medical staff return all unused medications to the prison's pharmacy. In two different public dumpsters outside the Draper prison site, our audit team found inmates' personal health information, along with hazardous medications that should have been retained and returned to the pharmacy. Furthermore, management needs to ensure that biohazard bins are locked and secured.

Management Needs to Ensure That Personal Health Information Is Protected and Unused Medications Are Secure

Pill packets (blister packs) with medications used at pill lines contain personal health information and unused medication. Medications in pill packets that are stamped "retained" are to be retained by clinical staff and returned to the pharmacy. These pills, if unopened, can be reused by the pharmacy. All other pill packets are to be securely shredded after use. As shown in Figure 3.3, we found pill packets containing personal health information, patient treatment sheets, a used syringe (which should have been disposed of in a biohazard waste container), and unused medications (which should have been retained and returned to the pharmacy) in two public dumpsters outside the prison. Medical staff are supposed to return all unopened pill packets to the pharmacy and shred any identifiable personal health information.

We found patient treatment sheets, pill packets containing personal health information, and a used syringe in two public dumpsters outside the prison.

Figure 3.3 Personal Health Information Such as Prescriptions, Treatment Sheets, and Medication Refill Requests Were Found in Public Dumpsters Outside the Prison. All prescriptions and treatment sheets are to be securely shredded, and syringes should be placed in a biohazard waste container.



Source: Auditor generated

According to statute, all medical records should be protected.

According to ***Utah Code 63G-2-302(1)(b)***, "The following records are private: records containing data on individuals describing medical history, diagnosis, condition, treatment, evaluation, or similar medical data." Additionally, the Bureau's training manual states the following:

> A public employee or other person who has lawful access to any private or controlled record and who intentionally discloses or provides a copy of a private or controlled record to any person knowing that such disclosure is prohibited is guilty of a class B misdemeanor.

When we first found personal health information discarded in the dumpsters, we alerted Bureau management. Four weeks later, our audit team checked the public dumpsters a second time and found more pill packs containing personal health information and unused medications, as shown in Figure 3.4.

Figure 3.4 A Second Inspection Found Prescriptions and Retained Medications in a Public Dumpster Outside the Prison. All prescription information is to be securely shredded, and all retained medications are to be returned to the pharmacy.

Source: Auditor generated

Four weeks later, we found more pill packets containing personal health information and unused medications in a public dumpster outside the prison.

We immediately alerted Bureau management a second time to let them know that personal health information and medications were still being discarded.

Management Needs to Ensure Biohazard Bins Are Secure

Besides checking the public dumpsters for discarded personal health information, we also inspected the biohazard bins at the Draper prison site and found that one was unlocked. Bureau management should ensure that biohazard bins are secure.

Bureau Management Needs to Follow the Inmate Handbook Fee Schedule

The Bureau charges for mental health services, which is not in line with the inmate handbook.

Lastly, we found that the Bureau has been charging inmates copays for mental health services, even though the inmate handbook states that there is no charge for these services. Between fiscal years 2018 and 2021, 165 charges for mental health services, totaling $825, were recorded. We were able to document this deficiency by analyzing three years of copay data. Bureau management needs to review its practice and ensure inmates are not being charged for mental health services; conversely, the Bureau could change the inmate handbook to allow for this practice.

Recommendations

1. We recommend that the Clinical Services Bureau ensure that the use of emergency medical technicians in the prison is consistent with state statutes and best practices, and that licensed nurses (or other qualified medical professionals) are used in situations that require a level of skill and knowledge beyond what an EMT is certified for.

2. We recommend that executive management at the Utah Department of Corrections ensure that personnel in the Clinical Services Bureau fully comply with required NCCHC standards.

3. We recommend that the Clinical Services Bureau ensure compliance with statute regarding the protection of personal health information.

4. We recommend that the Clinical Services Bureau follow the inmate handbook regarding copays for mental health services.

Chapter IV
Administrative Oversight of Medical Services Needs to Improve

As described in Chapter II of this audit report, the primary reason for systemic deficiencies in delivering medical services to Utah inmates is inadequate oversight from multiple levels of personnel. The lack of oversight from the Clinical Services Bureau (Bureau, or prison medical) management has affected all levels of healthcare operations, including program administration. Finances lack controls, as individual incentive award programs circumvent administrative rules. There is also a need for increased transparency in funding allocations and for management to be proactive in creating and reporting meaningful program performance metrics. We also found that several of the Bureau's policies, procedures, and training materials are outdated.

The lack of oversight from Bureau management has affected all levels of healthcare operations, including program administration.

Individual Incentive Awards Circumvent Administrative Rule

Bureau management is in violation of *Administrative Rule* in three ways. First, nurses' overtime incentives exceed allowable amounts. Second, emergency medical technician (EMT) retention incentives lack proper approval. Finally, incentive programs are not in policy. This section addresses each of the three *Administrative Rule* violations in detail.

Bureau management is in violation of *Administrative Rule* in three ways. This section addresses each of the violations in detail.

Nurses' Overtime Incentive Exceeds Allowable Amount

Over the past six fiscal years (2016 to 2021), there have been multiple violations of *Administrative Rule* related to employee incentive programs. *Administrative Rule* specifies thresholds for individual incentive award amounts as follows:

Individual awards may not exceed $4,000 per pay period and $8,000 in a fiscal year, except when approved by DHRM and the governor.[33]

Without having prior approval from DHRM and the governor, the Bureau exceeded the award thresholds specified in rule.

Without having prior approval from the Department of Human Resource Management (DHRM) and the governor, the Bureau exceeded award thresholds specified in rule. Bureau management exceeded the threshold of $8,000 per fiscal year in three separate instances:

- 2016: One employee received $12,900 in incentive pay.
- 2017: One employee received $19,200 in incentive pay.
- 2021: One employee received $12,000 in incentive pay.

Bureau management also exceeded the threshold of $4,000 per pay period in one instance:

- 2016: One employee received $4,800 in incentive pay in one pay period.

We are not discouraging the use of incentive programs; rather, we are concerned that Bureau management is not compliant with state rules in administering incentive award programs.

Bureau management created the nurses' overtime incentive program to remain competitive in hiring and retaining nurses. As mentioned in Chapter III, nurses are critical to the proper delivery of medical services in Utah prisons. These incentive programs are an important recruiting and retention tool; however, management has not ensured adherence to *Administrative Rule* and policy when considering such programs. The Bureau currently employs approximately 205 full-time employees, 61 of whom are nurses, and has collectively awarded more than $570,000 in incentive awards over the past five fiscal years (2016 to 2020). To be clear, we are not discouraging the use of incentive programs. Rather, we are suggesting that Bureau management demonstrate awareness of applicable rules and provide careful oversight of implemented incentive programs.

As a result of this audit, Bureau management began working with DHRM to find a compliant solution for addressing compensation issues. Subsequently, DHRM now recognizes overtime hours worked as a shift differential[34] rather than an incentive award. Had Bureau management been more attentive, these issues may have been resolved

[33] *Administrative Rule* R477-6-7(1)(b).

[34] A shift differential refers to the extra, or premium pay certain employees receive for working outside normal business hours.

more quickly, and *Administrative Rule* violations could have been avoided. Another entity that uses shift differentials to compensate its licensed practical nurses and registered nurses is the Utah State Hospital. Bureau management could have taken the opportunity to consult with industry professionals and discuss possible solutions for addressing issues related to recruiting, retention, and compensation.

EMT Retention Incentive Lacks Approval Documentation

On February 5, 2016, the then executive director of the Utah Department of Corrections approved a retention bonus pay program for EMTs. The proposal was intended to be a "short-term fix" for the Bureau, which was having difficulty retaining EMTs. The Bureau proposed to offer EMTs a bonus of $250 per paycheck per month, for a maximum of 18 months. In other words, an EMT could receive up to $9,750 in bonus pay over an 18-month period.[35] However, after the program was approved, it did not receive administrative oversight. This is another example of Bureau management's lack of careful oversight.

The 18-month program that was intended to be a short-term fix was still awarding retention bonuses four years later, with the last round of bonuses being distributed to EMTs at the beginning of September 2020. The lack of oversight resulted in multiple EMTs exceeding the $9,750 maximum. Although the program had received initial approval, neither DHRM nor the Bureau was able to locate approval documentation allowing management to extend the program beyond the original 18-month timeline. Market-based bonuses (such as retention bonuses) require DHRM approval, according to *Administrative Rule*.

The 18-month program that was intended to be a short-term fix was still awarding retention bonuses four years later.

> An agency may award a cash bonus as an incentive to acquire or retain an employee with job skills that are critical to the state and difficult to recruit in the

[35] There are 26 pay periods in one calendar year (12 months); therefore, there are 39 pay periods in an 18-month period (26 + (26/2) = 39). A retention bonus of $250 per paycheck, over an 18-month period, equates to a maximum of $9,750 (39 * $250 = $9,750).

> market. Any market-based bonuses shall be approved by DHRM.[36]

If Bureau management had recognized the need to continue EMT retention incentives beyond the original 18-month mark (July 2017), management should have sought DHRM's approval to extend the program.

Incentive Programs Are Not in Policy

Neither the nurses' overtime incentive program nor the EMT retention incentive program is mentioned in policy, as required by *Administrative Rule*. *Administrative Rule* plainly states the requirement for agencies to include incentive awards and bonuses in policy:

> Only agencies with written and published incentive award and bonus policies may reward employees with incentive awards or bonuses.[37]

The human resources field director at DHRM noted that, at a minimum, Bureau policies should make a general statement regarding implemented individual incentive award programs and bonuses.

The human resources field director at DHRM noted that, at a minimum, the policy should make a general statement that the Bureau will implement bonuses and awards for the nurses' overtime incentive program and the EMT retention incentive program. We recommend that the Bureau follow all aspects of *Administrative Rule* when implementing individual incentive award programs and bonuses.

Management Should Be More Transparent in Funding Allocations

The Bureau has been consistently underspending in personnel services and redirecting those funds to pay outside providers.

Bureau management should be more transparent in how funding is allocated. Over the past five fiscal years (2016 to 2020), the Bureau has been consistently underspending in personnel services[38] and redirecting those funds to pay outside providers. The cumulative total of redirected funds from personnel services over the five-year period is $11.3 million. Conversely, outside provider payments required an additional $9.6 million to satisfy the deficit. We note this pattern for

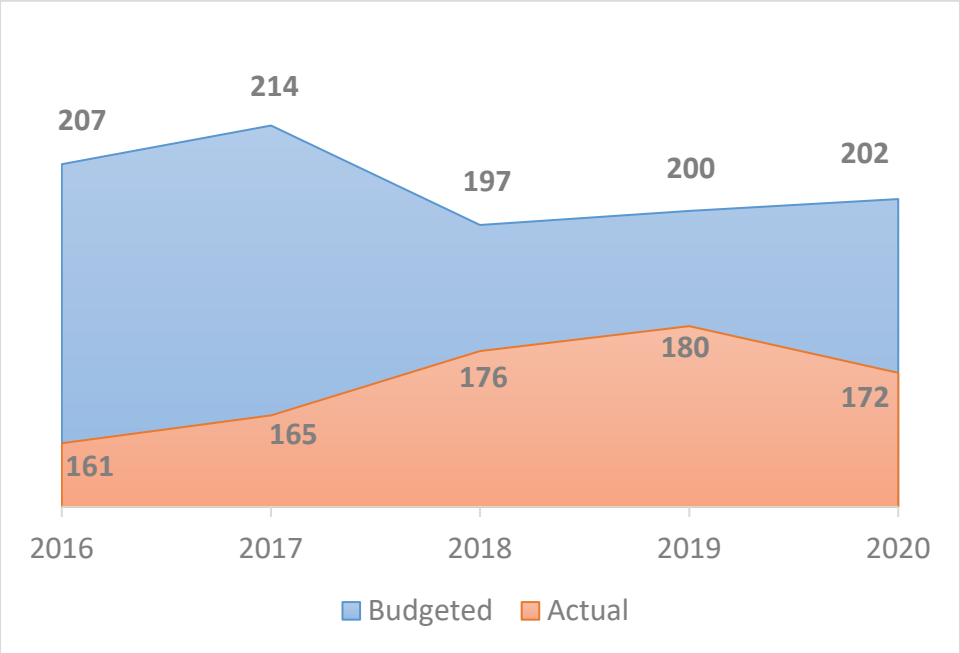
[36] *Administrative Rule* R477-6-7(4).
[37] *Administrative Rule* R477-6-7(1).
[38] Personnel services include regular salaries and wages, paid leave, paid overtime, incentive awards, state retirement, health insurance, dental insurance, long-term disability insurance, and other personnel-related expenditures.

two reasons. First, it provides an opportunity for Bureau management to be more transparent in how program funds are used. Second, it provides an opportunity for Bureau management to be proactive in recruiting and retention efforts.

All positions within the Bureau are funded, whether they are filled or not. For example, Figure 4.1 shows that in fiscal year 2020, the Bureau budgeted for 202 full-time positions; however, only 172 positions were filled. This means the Bureau received funding for 30 unfilled positions. While the Bureau is authorized to move money within the medical services line item, our analysis shows that funds intended for full-time equivalent (FTE) employees are being redirected to other sources. For example, the outside provider payment deficit was largely funded by money intended for personnel services. We recommend that Bureau management be more transparent with the Legislature in how program funds are being used.

All positions within the Bureau are funded, whether they are filled or not.

Figure 4.1 Actual FTE Counts Are Significantly Lower Than Budgeted FTE Counts. The blue area represents budgeted and funded FTEs, whereas the orange area represents actual FTEs. Over a five-year period, funded positions exceeded actual positions by an average of 33 FTEs.



Source: Governor's Office of Management and Budget

In fiscal year 2020, the Bureau received funding for 30 unfilled positions.

While data show that recruiting efforts for vacant positions are ongoing, we believe that proactive and creative solutions, such as an

education loan repayment program, may help address the gap in funding as it relates to actual FTEs.

Performance Metrics Need to Be Improved and Updated

Performance metrics do not reflect actual operations, indicating inadequate oversight by Bureau management.

Performance metrics do not reflect actual operations, indicating inadequate oversight by Bureau management. For example, in fiscal year 2020, the Bureau reported five performance metrics to the Legislature. Two of the five metrics relate to the percentage of inmate healthcare requests (ICRs) processed within a specified timeframe. More specifically, the ICR timeline for addressing and closing requests for medical services is three business days. While interviewing Bureau staff, we found that nurses, EMTs, schedulers, and providers had never heard of this performance metric. Additionally, staff reported that the metric is unreasonable, stating that addressing and closing ICRs within three business days is not feasible. In addition to the lack of staff alignment regarding performance measures, we also question the parameters used to generate this metric, how it is being calculated, and how it is reported to the Legislature.

Because the method of ICR submission is manual, there are no available data to accurately track the amount of time from when the ICR is submitted to when it is collected.

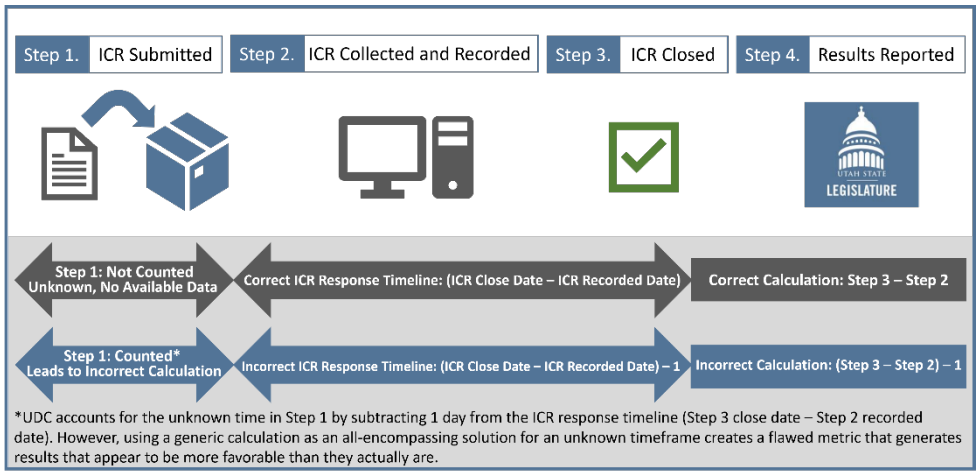
Figure 4.2 illustrates how ICR response timelines are calculated. While ICRs can be submitted in numerous ways, the most common way is to fill out a request form. When an inmate submits an ICR, the written request is placed in a secure collection box. Because this method of submission is manual, there are no available data to accurately track the amount of time from when the ICR form is submitted to when it is collected (see step 1 in Figure 4.2). Once the ICR form is collected by medical staff, it is entered in the prison's electronic medical record (EMR) system. After the request is entered in the EMR system, it is given an electronic time stamp, which includes the date the request was recorded (see step 2 in Figure 4.2). Once an inmate sees a provider or receives medication, or the request is resolved in some other way, the ICR is considered "closed" (see step 3 in Figure 4.2).

When Calculating the ICR Response Timeline, the Utah Department of Corrections Uses a Generic Calculation, Making the Metric Appear More Favorable. The amount of time between receiving an ICR and closing it is referred to as the ICR response timeline. Rather than calculating the percentage of ICRs addressed

and closed within three business days (the correct response timeline calculation in Figure 4.2), the Utah Department of Corrections (UDC) changed the number of business days by subtracting one from the total (the incorrect response time calculation in Figure 4.2). In other words, an ICR that actually took four business days to address and close is represented in the data as three business days (4 – 1 = 3). Therefore, a four-business day response time is counted as meeting the three-business day metric and is reported as such. We believe that calculating and reporting the metric in this way is incorrect and misleading.

UDC changed the data when calculating the ICR response timeline.

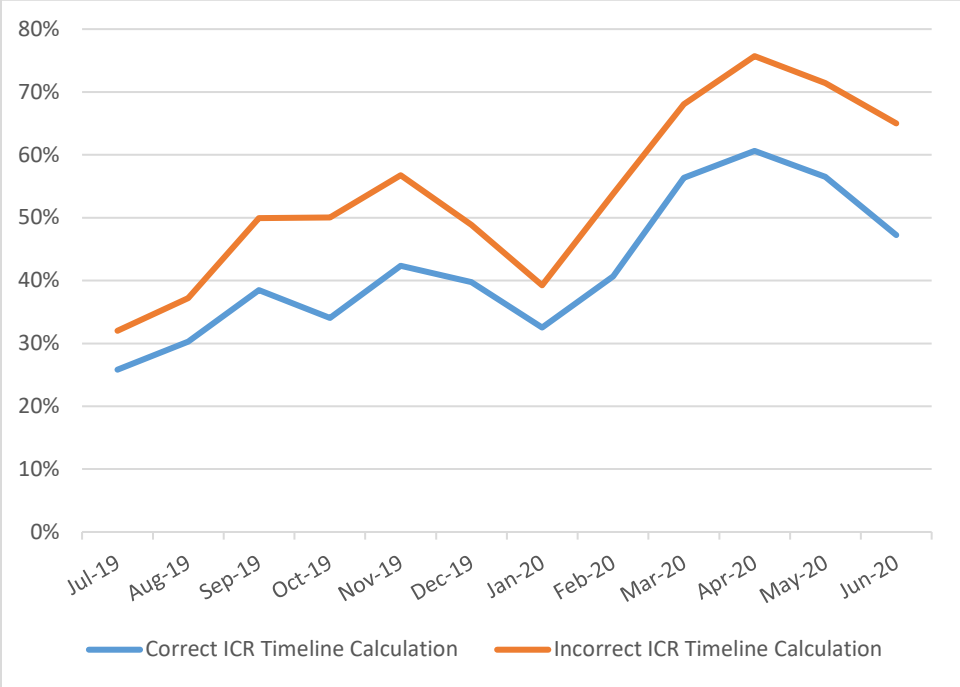
Figure 4.2 ICR Data Reported to the Legislature Are Incorrect. UDC accounts for the unknown window of time in Step 1 by subtracting one day from the ICR response timeline. We believe that calculating and reporting the metric in this way is incorrect and misleading.



Source: Auditor generated

Figure 4.3 shows the variation between the correct and incorrect calculations of this metric. On average, the two calculations differ by about 12 percentage points.

Figure 4.3 The Current Method of Calculating the ICR Response Timeline Is Misleading. The blue line represents the correct method of calculating the ICR response timeline, whereas the orange line represents the incorrect method. The Legislature is being told that a higher percentage of ICRs are addressed and closed within three-business days than what is actually occurring. For example, the orange line incorrectly shows that in June 2020, nearly two-thirds (65 percent) of ICRs were addressed and closed within three business days.



Source: Utah Department of Corrections and auditor analysis
** The parameters used to generate this metric exclude 15 percent of usable ICR data.*

Using the correct method of calculation, we recreated the metric and found that the data did not represent what was being reported to the Legislature.

This performance metric does not reflect actual program operations.

Using the correct method of calculation, we recreated the metric (blue line) and found that the data did not represent what was being reported to the Legislature (orange line). Furthermore, this performance metric does not reflect actual program operations. Bureau management noted that the target ICR response timeline is 15 days, not three business days.[39] Therefore, we recommend that the Bureau create meaningful performance metrics that adequately reflect program activity, and clearly communicate these metrics to all Bureau staff.

[39] Chapter III of this audit report describes the ICR process in greater detail and highlights our concerns with these internal practices.

Policies, Procedures, and Training Materials Are Outdated

It is critical that Bureau management regularly review policies, procedures, and training materials for the proper administration of inmate healthcare. A regular review ensures the safety and protection of both medical staff and inmates. There are several internal policies and procedures that govern medical services at both prison sites. Additionally, the National Commission on Correctional Health Care (NCCHC) requires healthcare policies and procedures to be reviewed at least annually. Bureau management provided us with signed cover sheets indicating that nursing and EMT protocols had been reviewed over the last two years; however, upon further examination, we found that the documents in question were not updated. For example, the review dates listed throughout the original documents had outdated coversheets and had not been adjusted to reflect the most current date calling into question the level of review completed. The following bullet points summarize the review dates listed on several of the Bureau's policies, procedures, and training materials.

NCCHC requires healthcare policies and procedures to be reviewed at least annually.

- The last formal approval of the prison's drug formulary[40] was in January 2019. Conversely, the state's Public Employees Health Program reports updating its formulary for generic drugs monthly and newly approved drugs quarterly. Frequent updates ensure that the most current clinical guidelines are being used and may result in lower cost-sharing options.

The review dates listed on several of the Bureau's policies, procedures, and training manuals do not meet NCCHC's annual review threshold.

- Nursing protocols were last updated seven years ago, in November 2014.
- EMT orientation materials include training sections that have not been updated since July 2008, more than 13 years ago.

[40] A formulary is a list of brand name and generic prescription drugs that are approved to be prescribed by a particular health insurance policy.

Policies and procedures from surrounding states had review dates within the last year and were updated as necessary.

We also reviewed policies and procedures from surrounding states such as Arizona and Nevada. The policies and procedures from these states had review dates within the last year and were updated as necessary. To better protect medical staff and ensure that inmates are receiving consistent and appropriate care, we recommend that Bureau management review and update all policies, procedures, and training materials.

Recommendations

1. We recommend that the Clinical Services Bureau follow *Utah Administrative Rule* when implementing incentive programs.

2. We recommend that the Clinical Services Bureau be transparent with the Legislature in how program funds are being used.

3. We recommend that the Clinical Services Bureau create meaningful performance metrics that reflect program activity.

4. We recommend that the Clinical Services Bureau ensure that its formulary, procedures, policies, and training materials are all up to date.

Appendices

Appendix A

Recommendations

This report made the following 16 recommendations. The number convention assigned to each recommendation consists of its chapter followed by a period and recommendation number within that chapter.

Recommendation 2.1

We recommend that the executive director of the Utah Department of Corrections ensure that all recommendations in this audit are adequately implemented.

Recommendation 2.2

We also recommend that the executive director of the Utah Department of Corrections launch an internal review to determine if additional changes not addressed in this report are needed regarding operations and/or staff.

Recommendation 2.3

We recommend that the Clinical Services Bureau ensure that providers and other medical staff define the term "monitor" in patient charts with specific parameters on a case-by-case basis.

Recommendation 2.4

We recommend that the Clinical Services Bureau increase oversight to ensure that appropriate case-by-case patient follow-up procedures are being completed.

Recommendation 2.5

We recommend that the Clinical Services Bureau ensure that all patients have access to:

a. Appropriate and timely clinical judgments rendered by a qualified healthcare professional.

b. Correct treatments and medications for corresponding diagnoses.

Recommendation 2.6

We recommend that the Clinical Services Bureau follow internal policies and professionally recognized standards regarding the administration of insulin and the oversight of inmates with diabetes.

Recommendation 2.7

We recommend that the Clinical Services Bureau create policies and procedures to effectively manage nutrition and medical care for diabetic patients during disruptions or delays to the normal schedule.

Recommendation 2.8

We recommend that the Clinical Services Bureau develop policies, where appropriate, that help the organization be more compliant with CDC standards regarding medical issues such as the COVID-19 pandemic.

Recommendation 3.1

We recommend that the Clinical Services Bureau ensure that the use of emergency medical technicians in the prison is consistent with state statutes and best practices, and that licensed nurses (or other qualified medical professionals) are used in situations that require a level of skill and knowledge beyond what an EMT is certified for.

Recommendation 3.2

We recommend that executive management at the Utah Department of Corrections ensure that personnel in the Clinical Services Bureau fully comply with required NCCHC standards.

Recommendation 3.3

We recommend that the Clinical Services Bureau ensure compliance with statute regarding the protection of personal health information.

Recommendation 3.4

We recommend that the Clinical Services Bureau follow the inmate handbook regarding copays for mental health services.

Recommendation 4.1

We recommend that the Clinical Services Bureau follow *Utah Administrative Rule* when implementing incentive programs.

Recommendation 4.2

We recommend that the Clinical Services Bureau be transparent with the Legislature in how program funds are being used.

Recommendation 4.3

We recommend that the Clinical Services Bureau create meaningful performance metrics that reflect program activity.

Recommendation 4.4

We recommend that the Clinical Services Bureau ensure that its formulary, procedures, policies, and training materials are all up to date.

Appendix B

Medical Consultant Report for the Office of the Legislative Auditor General for Utah

Introduction: I am a board-certified family physician with over 45 years of clinical experience in a variety of settings. I am familiar with quality standards of care and have performed many reviews and audits of clinical care. My review was primarily focused on the review of the charts of inmates that were selected by the audit team. I was also able to participate in a number of the interviews with clinical staff.

Setting: This is a review of the quality of care being provided to inmates in the state's prison system. My focus was on the Draper facility but did include a small number of chart reviews for inmates in the Gunnison facility. The Draper facility houses nearly 2,800 inmates. There is clinical staff for mental health care which I did not review. On the medical care side, there are three physicians and eight physician assistants who comprise the provider team. They are supported by 38 registered nurses (12 are considered to be senior nurses), and 22 emergency medical technicians who are referred to as the "med techs." The medical director, a board-certified family physician, is primarily located at the Gunnison facility, but usually comes to Draper once a week.

Components of Quality of Care: There are many factors that influence the quality of care that a patient receives, and I will focus on a few of the most important factors and discuss each factor as it impacts the Draper prison facility.

- The adequacy of the clinical staff including the number of providers and the training and experience of those providers.
- The adequacy of the support staff for the providers including the number of support staff and the training/qualifications of that staff.
- The adequacy of funding to support adequate personnel and adequate treatments that are indicated for the patients being served.
- The adequacy of the facilities in which patients are treated. For the Draper facility this would include the clinic space and the infirmary space. Facility adequacy is a function of the physical space, the equipment available, and the support staff available.
- The adequacy of the medical record system including the ability to quickly retrieve patient information and have it displayed in a functional fashion.
- The adequacy and availability and utilization of treatment protocols for serious conditions (can also include common conditions) that would assist all providers and support staff in providing consistent, quality care.
- The presence of an active, internal quality review program that can identify and address issues sooner than later and implement appropriate corrective actions.
- Finally, the adequacy of the overall functioning of the health care system, i.e. how well all these parts are working together to provide quality care.

The Patient Population: As noted above, this facility houses nearly 2,800 inmates. Based upon the review of 76 patient charts, it is clear that this is a very sick population as compared with an "outside" population of patients. Most of the inmates had problem lists that documented between 6 and 20 medical problems which included 4–6 serious, chronic health care problems, including: diabetes mellitus (types I and II), hypertension, hyperlipidemia, chronic obstructive pulmonary disease, hepatitis (primarily type C), congestive heart failure, cancer, and serious infections

(particularly COVID19 over the past 18 months). These medical issues are further complicated by these inmates' mental health concerns. From my review, it would appear that approximately 50% of the inmates suffered from significant mental illness.

Quality of Care Issues:

1. **Provider Staffing**
   A. I believe that the number of medical providers is generally adequate to care for this population as long as there are no extenuating clinical circumstances. Recognizing that staffing must be adequate enough to cover provider absences during leave or sick time off.
      i. I was impressed by the commitment to provide quality care by the providers that I interviewed. These are well trained clinicians who want to do their very best in caring for this challenging population.
   B. The increased workload imposed upon the clinical staff by the COVID19 pandemic as it impacted the prison population, made the number of providers inadequate to maintain a high quality of clinical care for all patients, but especially for the COVID19 patients.
   C. Provider recruitment, for all levels of health professionals, has always been a challenge for this facility (and this is true of most prisons and jails in our nation), and I will address this issue in my recommendations.

2. **Support Staff**
   A. I am concerned with the use of emergency medical technicians (basic) as the front-line clinical staff who interact with the inmates on a daily basis.
      i. Emergency Medical Technicians (EMTs) have very limited clinical training which is focused on responding to medical emergencies. They do not have patient assessment education and training beyond those emergency situations. Since the vast majority of medical concerns from the inmates do not involve the medical emergencies for which EMTs are trained, they are not appropriately suited to correctly evaluate these inmates and their medical concerns.
      ii. According to state law, EMTs are only permitted to work in an emergency health care setting, which is appropriate to their training, such as on an ambulance or in an emergency room.
      iii. While EMTs may administer medications on the order of a licensed health care provider, the vast majority of the medications that they are charged with administering would not have been included in their EMT training. Lack of familiarity with a medication is concerning because the EMT would not know what the medication is treating, and the expected outcome and they would not be familiar with common side effects or adverse reactions. EMTs are assigned to the "pill lines" where they distribute all the medications that have been ordered for each inmate. This role is not really appropriate for the kind of training that an EMT receives.
      iv. In contrast, the Gunnison facility uses nurses for the "med tech" role. This role is legally within the scope of practice of a registered nurse because they have received education and training in overall patient assessment.

v. There is not adequate supervision of the EMTs/Med techs by the nursing staff in the Draper facility. Adequate supervision could partially (but not completely) overcome the limited training of the EMTs/Med techs.
vi. Clinical leadership for the prison states that they cannot afford, nor can they recruit, the number of nurses that would be needed to replace the EMTs. I will also address this issue in my recommendations.

3. **Funding**
   A. There are significant funding issues related to the recruitment and retention of provider staff and nursing staff that I will address in my recommendations.
   B. The COVID19 pandemic exposed additional funding concerns regarding adequate staffing and adequate treatment of this disease.

4. **Facilities**
   A. I did not inspect the Draper prison's clinical facilities as part of this audit. I have however, for a past audit, toured those clinical facilities. While this facility is old and due for replacement, the facilities can be considered adequate even though the spaces are limited in size and the infirmary is also small. From my prior visit, I felt that the clinical facilities had adequate equipment and generally had adequate support staff.

5. **Medical Record System**
   A. The state prison uses an electronic health record (EHR) known as M-Track. This is a very outdated, slow and complex system that does not have the ability to display all of a patient's information on a single screen (e.g., encounters, lab results, consultation reports, treatments) so one has to close out one view (e.g. encounters) in order to see another view (e.g. lab results). This system is inefficient and therefore wastes provider time. Further, the limited availability of information can easily lead to diagnostic and/or treatment errors.
   B. When the prison moves into their new facility, I have been told that they will be getting a new EHR, which is long overdue. I am not familiar with the brand of EHR that has been selected so I can't comment on its adequacy. However, I was very disappointed to learn that the providers have had minimal input on the selection of this new record system. Since providers are the key users of an electronic health record, it would be highly appropriate for them to have been consulted and allowed to "test drive" the EHRs under consideration prior to a final purchase decision.

6. **Treatment Protocols**
   A. My concern is for a protocol relating to the care of COVID19 positive patients. The medical director stated that they have a protocol, and a copy was to be sent to auditor staff. Based upon our interview with the medical director, I was concerned that financial issues were preventing inmates from being treated to the community standard of care. I have the following concerns:
      i. Patients testing positive for COVID19 need to be isolated and quarantined, and this was reportedly being done, but I was not able to

document that. Patients who test positive and are high risk need to be closely monitored, at a minimum, daily checking of their vital signs, especially their temperature and their oxygen saturation. When there is any evidence of a patient's condition worsening, those checks should occur more frequently, e.g. 2-4 times/day.

a. For several patients who were diagnosed with COVID19, the provider would request "monitoring" or "increased monitoring" but those orders did not contain any specificity such as requiring the checks noted above.

7. **Quality Review Program**
   A. The prison's clinical program does have an active quality review program. Audit staff has received copies of agendas and minutes for some of their meetings. I have not reviewed any of those documents and have not been able to attend one of their meetings in order to comment on the adequacy of their process.

8. **Systems Issues** (in addition to all those issues already presented)
   A. Inmates report medical concerns/requests by filling out an Inmate Care Request (ICR) form and giving it to the Med Tech who is doing "pill line" in their housing unit. Unfortunately, the med techs have neither the required skills nor the time to carefully assess these concerns in order to determine their potential urgency. The Draper facility averages 290 ICRs per day!
   B. ICRs are to be triaged by a registered nurse who makes a decision on what action needs to be taken: schedule an emergent clinic visit (could take from 1 day to 2 weeks), schedule a routine clinic visit (could take 1-2 months), or in some cases just a medication refill is required. For the most part, this triage process works adequately when we can assume that the written complaint adequately reflects the problem since neither the patient, nor the med tech have the skills needed to adequately assess many types of complaints. ICRs have to be "closed" by someone. Ideally, this happens after an appropriate visit, or after the medication was re-ordered, etc. However, there were occasions when an ICR was "closed" without the patient ever being evaluated. I considered some of these closed but not evaluated ICRs to be concerning because of a needed medication or the complaint was medically concerning.
   C. The next step occurs when the triage nurse sends the ICR to the clinic schedulers. I did not personally explore this stage, but audit staff has done so. Once again, there is a concern with how these appointments are prioritized.

9. **Chart Reviews:** I reviewed 76 charts as selected by the legislative auditors.
   A. A number of charts were for COVID19 positive patients, including several who died from that disease. In some of the charts, the care provided was appropriate even when the ultimate outcome was death. This is true of patients in community settings. However, there were some charts where the patient's monitoring was not performed as needed. One patient did not have a follow-up check for 4 days; at which time he was much sicker. Another patient was found to have a below normal oxygen saturation, but no action was taken until he was much sicker two days later.

B. I have concerns about the care of diabetic patients. There does not appear to be a strong emphasis on controlling this disease in order to prevent the predictable complications. Inmates are allowed to have abnormal blood sugar levels and abnormal hemoglobin A1c levels without any special action being taken. In addition, the administration of insulin (especially short acting types) is not routinely tied to when the inmate has access to food. When using regular insulin, a patient needs to eat within 30 minutes of administration. If the insulin is given more than 30 minutes after the inmate has eaten, the blood sugar level will already be abnormally high before the insulin can take effect.

10. **Summary**: My review of medical cases at the Utah Department of Corrections found some significant concerns that need to be immediately addressed. The concerns I identified are systemic in nature and resulted in some inmates receiving either insufficient or inappropriate care. Thankfully, most inmates in my review did receive sufficient care, but I am concerned that if systemic weaknesses are not corrected concerns in care could multiply. Some of the concerns I identified included, but are not limited to, unreasonable delays and inconsistencies in critical medications, failure to follow a pharmaceutical regimen prescribed by a specialist, inmate care requests that had not been acted upon or completed, unreasonable delays in appropriate exam and treatment plans, and failure to follow standards in statute (e.g., using EMT's in a manner outside of their training). Finally, the degree of insufficient and/or inappropriate care that some inmates received raises concerns about the overall operations and management of the prison medical system.

11. **Recommendations**

A. I believe that the state legislature needs to fund a loan repayment program specifically for the state prison system. This program should be open to health care providers including physicians, physician assistants, nurse practitioners, registered nurses, dentists, and pharmacists. I would recommend that such a program be administered by the Utah Department of Health (UDOH) which has experience with these types of programs. The loan repayment amounts and duration of eligibility for this funding should be determined through discussions between the prison's clinical leadership team and the UDOH staff who will administer the program and write the rules to implement such a program.

B. The legislature needs to fund salary schedules for health care providers in the prison system at a competitive level.

C. The legislature needs to fully fund the pharmaceutical needs at the state prison. This requires that leadership in the Department of Corrections carefully prepare a justifiable budget to present to the Governor's Office and state legislature that reflects these costs.

D. The prison's health care providers need to be given early access to and training on the new electronic health record system. This needs to be done well in advance of its actual implementation so that there is a smooth transition from the old system.

E. I support the development of treatment protocols for chronic conditions and other, frequently encountered conditions. These protocols will serve as orientation material for new providers and as the basis for quality review of the care being

given for those conditions. However, treatment protocols should reflect the current standard of care in the community at large. If there are reasons why this is not possible, it should be explained within the protocol.

F. The current system in which ICRs go to EMTs, and then to triage nurses, and then to schedulers, and finally result in some action or a visit with a provider, needs to be thoroughly re-evaluated. As noted earlier, the Draper facility needs to begin a process to phase out the use of EMTs as med techs and replace them with RNs. By having competitive salaries and a loan repayment opportunity, this should be feasible. There also needs to be ongoing review of the actions of the schedulers to assure that patient needs are being met on a timely basis. This type of oversight can be done by the senior registered nurses on staff.

Respectfully submitted on October 4, 2021.

Marc E. Babitz, M.D.

CURRICULUM VITAE

MARC E. BABITZ, M.D.

EDUCATION

High School: Hiram W. Johnson Senior High School
Sacramento, California
Fall 1962-Spring 1965

Undergraduate: University of California, Davis Campus
Davis, California
Fall 1965-Spring 1968

Medical School: University of California, San Francisco
School of Medicine
Fall 1968-Spring 1972

Degrees received: B.S. - Medical Sciences, Spring 1969
M.D. - Spring 1972

Internship: Community Hospital of Sonoma County
Family Practice Residency Program
Santa Rosa, California
July 1, 1972-June 30, 1973

Residency: Community Hospital of Sonoma County
Family Practice Residency Program
Santa Rosa, California
July 1, 1973-December 31, 1975
Note: the completion of my residency training requirements was obtained in conjunction with my Public Health Service, as noted below, on June 30, 1976)

Other: Contemporary Executive Development Program
School of Government and Business Administration
George Washington University
Washington, D.C.
January 29 - March 8, 1985
(Awarded 9.0 CEUs for course)

Mass Casualty Care Services - 1984
Andrews Air Force Base, Maryland
June 24-29, 1984
Fort A.P. Hill, Virginia
September 10-15, 1984

Advanced Trauma Life Support Certification
Uniformed Services University of Health Sciences
Bethesda, Maryland
April 24-26, 1985

Advanced Cardiac Life Support Certification
National Institute of Health
Bethesda, Maryland
May 1986
Advanced Life Support in Obstetrics
University of Utah
Salt Lake City, Utah
August 1995

BOARD CERTIFICATION

Diplomate of the American Board of Family Practice, 1976 to 2014. Passed the re-certification examinations given in July 1982, July 1988, July 1994, July 2000, July 2007 and November 2014.

LICENSURE

State of California - Certificate No. G 025179, issued 1973.
(inactive status effective 1984)

District of Columbia - License No. 14955, issued 12-31-84.
(inactive status effective 1989)

State of Colorado - License No. 28886, issued 07-07-88.
DEA number BB1691434, non-practicing license, expires 05-31-99.

State of Utah - License No. 94-284584-1205, issued 12-28-94 (expires 1/31/2022).
Controlled Substance License No. 94-284584-9915.
DEA number - BB1691434, expires 07-31-21.

EMPLOYMENT HISTORY (since residency)

Clinic provider, Salt Lake Health Clinic of Utah (operated by the State of Utah, Dept. of Health). Working as a family physician to maintain my continuity practice from my years as a full-time employee, and to support the clinic as patient demands dictate. May 2021 – present.

Retired from full-time employment with the State of Utah on March 1, 2021.

Final Position before full-time retirement (under a new Director)

Director, Division of Family Health and Preparedness, Utah Department of Health, August 2020 – March 2021. Continued to serve as the Medical Director for the Health Clinics of Utah and Family Dental Plan (the Ogden and Provo medical clinics were closed on August 15th and the Ogden dental clinic closed on August 31st). The Salt Lake Dental clinic closed on October 31st. The dental clinics were successfully transferred to the University of Utah's School of Dentistry. The Salt Lake medical clinic remains open. Responsible for oversight of four Bureaus: Bureau of Emergency Medical Services and Preparedness; Bureau of Licensing and Certification; Bureau of Maternal and Child Health; and Children with Special Health Care Needs. Provide oversight and consultation for the Department's Center for Medical Cannabis and the Background Criminal Screening program.

Previous

Deputy Director, Utah Department of Health and Medical Director, Health Clinics of Utah; October 2016 – August 2020. Primary responsibility is to support the Director in whatever areas are needed (e.g., national accreditation, legislation, implementation of programs for pharmacist dispensing of Naloxone and hormonal contraceptives, personnel, collaboration with local health officers/departments). A major focus is on supporting the Public Health programs in the Divisions of Disease Control and Prevention and Family Health and Preparedness. Also, supervising the Office of American Indian/Alaska Native Health Affairs, the Office of Health Disparities Reduction, and our newest program for Medical Cannabis. Oversight of our Center for Medical Cannabis includes review and approval of CME programs; coordination of, and support for, the Cannabinoid Product Board; serving as Chair of the Compassionate Use Board; and ongoing consultation with Center staff, as needed. Health Clinics of Utah consists of 3 medical clinics (Ogden, Salt Lake and Provo), 2 fixed dental clinics (Ogden and Salt Lake) and a mobile dental clinic. This department has over 1,000 employees and an annual budget of approximately $3 billion (most of which is for the state Medicaid program whose director is a co-deputy director for the department).

Director, Division of Family Health and Preparedness, Utah Department of Health, September 2009 – October 2016. Also, serving as the Medical Director for the Health Clinics of Utah, Salt Lake Clinic, May 2011 – present. Responsible for oversight of: the Bureau of Primary Care; the Bureau of Emergency Medical Services and Preparedness; the Bureau of Child Development; the Bureau of Health Facility Licensing, Certification and Resident Assessment; the Bureau of Maternal and Child Health; and the Bureau for Children with Special Health Care Needs. This Division has over 300 full-time employees and an annual budget of over $130,000,000. Since July 1, 2011, serving as Medical Director for our Salt Lake Clinic, including supervising 2 FT PAs, and providing patient care.

Director, Division of Health Systems Improvement, Utah Department of Health, May 1, 2005 – August 2009 (part-time through June 2008, full-time as of July 2008). Responsible for oversight of: the Office of Primary Care and Rural Health; the Bureau of Emergency Medical Services and Preparedness; the Bureau of Child Care Licensing; the Bureau of Health Facility Licensing, Certification and Resident Assessment; the Bureau of Clinical Services (the state's medical and dental clinics for Medicaid patients); the American Indian/Alaska Native Health Initiative; and, the state's Patient Safety Initiative.

Professor (Clinical) and Director of Student Programs in Family Medicine, Department of Family and Preventive Medicine, University of Utah School of Medicine, December 1994 – June 2008 (Associate Professor 12/'94 – 6/'04). Responsible for the administration and oversight of the Department's medical student programs (pre-doc director), including the maintenance and expansion of the preceptor network, advisor to the Family Medicine Interest Group, director of the senior Honors/Career Track program, and advisor/mentor for students interested in family medicine careers. I served as the coursemaster for the "Social Medicine" course (1st and 2nd years), Family Medicine Clerkship (3rd year) and the Pubic/Community Project course (4th year).

Also served as the Principal Investigator for the Utah Area Health Education Center's federal grant (formerly served as the Senior Associate Director), instructed in the Physician Assistant

(PA) program and precepted FP residents. Other teaching responsibilities included the “Cultural Competence Mutual Respect” courses established by the Vice-President’s office, having served as a small group facilitator for the “Ethics” course taught annually to senior medical students. I have also taught in the College of Nursing’s Advanced Practice Nursing (NP) program and precepted NP students.

Uniformed Service

United States Public Health Service: On active duty from January 1, 1975 to December 31,1994. Assimilated into the Regular Corps on May 21, 1990 (permanent grade O-5, effective July 1, 1991). Retirement Rank: Captain, O-6.

Duty Stations: Region VIII, PHS - Regional Clinical Coordinator
Denver, Colorado
June 1, 1987 - November 18, 1994

Responsible for clinical oversight of federal programs assisting medically underserved populations in six states (CO, UT, WY, MT, SD, ND), including the National Health Service Corps, the community and migrant health center programs and the health care for the homeless program. Duties included consultation, education and training, and grant oversight.

NHSC Central Office - Chief Medical Officer
Rockville, Maryland
February 27, 1984 - June 1, 1987

Served as the lead physician representing over 3,000 NHSC physician assignees plus other clinicians serving in Health Professions Shortage Areas throughout the nation. Responsible for the development and implementation of national policy regarding the recruitment, selection, placement, support, and retention of these providers.

NHSC Field Station - Russian River Health Center
Guerneville, California
January 1, 1975 - February 16, 1984

Served as a rural family physician providing a full range of primary care services, including inpatient care and perinatal care in a medically underserved area. Also, served as the center’s medical director for seven years and as the center’s administrator for five years. Accomplishments included the recruitment of additional providers to the site, building of an expanded, modern clinical facility, development of community linkages and establishment of strong teaching linkages with health professions schools and residency programs.

HONORS / AWARDS

Recipient of the "Gold-Headed Cane" award upon graduation from medical school on June 10, 1972.

Recipient of the "Achievement Medal" for outstanding service to the United States Public Health Service - 1980.

Recipient of a Resolution of the Board of Supervisors of the County of Sonoma, State of California which proclaims a tribute to Marc Babitz, M.D. for exemplary service to Sonoma County - February 15, 1984.

Fellow of the American Academy of Family Physicians; awarded in Kansas City, Missouri; October 1984.

Recipient of the "Public Health Service Citation" for successfully directing the funding and construction of a new health center facility for the Russian River Health Center, Inc. - December 3, 1984.

Recipient of the "Commendation Medal" of the United States Public Health Service for nine years of excellent service at the Russian River Health Center and to the Guerneville, CA. community - December 3, 1984.

Recipient of the "Unit Commendation" of the United States Public Health Service for full participation in the Clearing-Staging Unit (Disaster Medical Assistance Team II) of the Health Resources and Services Administration - December 4, 1984.

Recipient of the "Outstanding Service Medal" of the United States Public Health Service for leadership in continuing medical education accreditation for professionals in the National Health Service Corps - April 15, 1987.

Recipient of the "Commander's Award" of the National Disaster Medical System for exceptional contributions to the Public Health Service - Rockville, Clearing-Staging Unit, serving as Deputy Commander from January 1986 through May 1987.

Recipient of the "Unit Commendation" of the United States Public Health Service from Surgeon General C. Everett Koop for participation on the Training, Awards and Recognition Workgroup of the Surgeon General's Revitalization Task Force - March 10, 1988.

Recipient of the "Unit Commendation" of the United States Public Health Service from Surgeon General C. Everett Koop for participation in the development of the prototype National Disaster Medical System/ PHS Clearing Staging Unit - April 21, 1988.

Recipient of the "National Emergency Preparedness Service Ribbon" of the United States Public Health Service from Captain Richard J. Bertin for contributions in establishing the Rockville Disaster Medical Assistance Team - May 11, 1990.

Recipient of the "Unit Commendation" of the United States Public Health Service from Assistant Surgeon General Robert Harmon for the development and implementation of a series of multi-regional training programs - May 22, 1990.

Recipient of the "USPHS Director's Award" from Dr. Don Weaver, Director of the National Health Service Corps, for exhibiting leadership, creativity, and ingenuity in the development of recruitment materials - January 17, 1991.

Recipient of a "U.S. Department of Health and Human Services Certificate of Appreciation" from Jane Artist, Regional Director, HHS, Region VIII, for my efforts with the PHS Health Promotion Program, "Live Life Litely" - January 17, 1991.

Recipient of a "U.S. Department of Health and Human Services Certificate" from Jane Artist, Regional Director, HHS, Region VIII, and Schuyler J. Baab, Deputy Under Secretary for Intergovernmental Affairs, DHHS, in recognition and appreciation of my outstanding contribution to our National Breast Cancer Awareness Month Activities - January 17, 1991.

Recipient of the "Outstanding Service Medal" of the United States Public Health Service for initiative and outstanding clinical leadership in PHS primary care programs during a period which required creative approaches to physician recruitment and retention activities to assure services to medically underserved populations - February 15, 1991.

Recipient of the “Recognition and Appreciation” Award of the U.S. Public Health Service Recruitment Program - June 17, 1991.

Recipient of the National Health Service Corps' Director's Award for "continual dedication, professional excellence and outstanding contributions to the mission of the National Health Service Corps" - March 1993.

Recipient of the Recognition Award from the Administrator of the Health Resources and Services Administration for "work as a part of the Hurricane Andrew relief effort" - January 1993.

Recipient of the President's Recognition Award of the Uniformed Services Academy of Family Physicians for "outstanding contributions made to uniformed Family Practice" - March 23, 1993.

Recipient of a Special Recognition Award from the National Migrant Resource Program, on behalf of migrant health providers in the mid-western U.S., for outstanding contributions to the improvement of Migrant Health. Presented at the Third Midwest Migrant Stream Forum October 29, 1993.

Recipient of the Special Assignment Service Ribbon, dated December 1992, from Surgeon General Antonia Novello in recognition of services provided in the aftermath of Hurricane Andrew. Presented July 11, 1994.

Recipient of the Crisis Response Service Award, dated December 1992, from Surgeon General Antonia Novello in recognition of services provided in the aftermath of Hurricane Andrew. Presented July 11, 1994.

Recipient of the Unit Commendation, dated December 1992, from Surgeon General Antonia Novello for exemplary performance of duty in the aftermath of Hurricane Andrew. Presented July 11, 1994.

Recipient of a Recognition Award from the Department of Family Medicine, University of Colorado Health Sciences Center for significant contributions, dedication, and loyalty to Family Medicine. Presented September 21, 1994.

Recipient of a Total Commitment Award from the Community Health Association of Mountain/Plains States for my long-standing commitment to the clinicians in Region VIII. Presented at the CHAMPS 9th Annual Primary Care Conference - October 7, 1994.

Recipient of an award from the Mountain/Plains Clinicians Network for "outstanding contributions and invaluable service in the forging of new models of clinician involvement in the delivery of primary care services to poor and underserved populations." Presented at the CHAMPS/MPCN Annual Primary Care Conference - October 7, 1994.

Recipient of the Meritorious Service Medal from the M. Joycelyn Elders, M.D., Surgeon General of the Public Health Service for exemplary performance of duty over the course of my career. Awarded on November 4, 1994.

Recipient of the National Health Service Corps' Directors Award for outstanding contributions to the mission of the National Health Service Corps, 1974 - 1994. Presented upon retirement, on November 18, 1994.

Recipient of a recognition award from the Office of Migrant Health, Bureau of Primary Health Care, Health Resources and Services Administration, for my "caring commitment to improving the health of migrant farm workers and their families." Presented upon retirement, on November 18, 1994.

First holder of the Thomas Fincher Harry Morton, M.D., Endowed Chair in Family Medicine, December 19, 1994 – Spring 2000.

Recipient of the Director's Award from the Bureau of Primary Health Care, U.S. Public Health Service, for outstanding contributions toward the Bureau's future direction and achieving its mission. Awarded on April 24, 1995.

Recipient of the Community Award for 1997 from the Junior League of Salt Lake City, in recognition of multiple volunteer efforts to improve our community's health, including support for the 1996 CARE FAIR, May 13, 1997.

Recipient of the National Health Service Corps Director's Award "for sustained, exemplary service in support of clinicians in medically underserved communities, and creativity in developing Community Oriented Primary Care programs." Presented by Dr. Donald Weaver, Assistant Surgeon General; Director, National Health Service Corps; on June 13, 1997.

Recipient of an award from the Junior League of Salt Lake City for my partnership with them to provide screening physical examinations at their annual C.A.R.E. Fair for underserved individuals and families, presented November 20, 1999.

Appointed as a Fellow of the National Consortium on Community-Based Medical Education, April 14, 2000.

Appointed as a Senior Fellow of the National Consortium on Community-Based Medical Education, April 9, 2001.

Nominated as the University of Utah School of Medicine's candidate for the "Humanism in Medicine Award" from the Association of American Medical Colleges and the Pfizer Humanities Initiative, November 2002. This award, as the University of Utah's faculty recipient, was presented on May 22, 2003.

Nominated for the University of Utah School of Medicine's Jarcho Teaching Award, which is the School of Medicine's most prestigious teaching award, April 2003.

Recipient of the Heather Belsey Award, University of Utah School of Medicine, for outstanding dedication to the homeless community and leadership to the students of the University of Utah School of Medicine, 2002 – 2003, presented Fall 2003.

Nominated for the University of Utah School of Medicine's Jarcho Teaching Award, which is the School of Medicine's most prestigious teaching award, April 2005.

Awarded the Thomas Fincher Harry Morton, M.D., Endowed Chair in Family Medicine, Spring 2005 – Spring 2008.

Recipient of the Legacy of Excellence Award from the Junior League of Salt Lake City, in recognition of 10 years of volunteer service and leadership for their C.A.R.E. Fair and to the medically underserved populations in our community, September 17, 2005.

Recipient of the University of Utah School of Medicine's Leonard W. Jarcho, M.D. Distinguished Teaching Award, which is the School of Medicine's most prestigious teaching award, May 2006.

Recipient of the 2009 Governor's Award for Excellence in Outstanding Public Service, in recognition of your extraordinary commitment to excellence in serving the citizens of Utah, June 4, 2009.

Recipient of a Distinguished Service Award from the Utah Medical Association "for dedicated service as a member of the UMA Board and Speaker of the House." September 15, 2017.

Nominated for UMA's 2020 Doctor of the Year by the Salt Lake County Medical Society. Was not chosen as the finalist. August 2020.

Recipient of the Utah Medical Association's 2021 Doctor of the Year. Presented at the annual House of Delegates meeting in Midway, UT, September 10, 2021.

Recipient of the Utah Academy of Family Physicians 2021 Family Medicine Champion Award. Presented at the annual business meeting in Salt Lake City, UT, September17, 2021.

EDUCATIONAL ACTIVITIES (Faculty Appointments)

Adjunct Professor of Pharmacy, College of Pharmacy, University of Utah, Salt Lake City, UT, 2011 – present.

Adjunct Professor of Nursing, College of Nursing, University of Utah, Salt Lake City, UT, March 22, 2010 – present.

Professor (Clinical Track) and Director of Student Programs in Family Medicine, Department of Family and Preventive Medicine, School of Medicine, University of Utah, Salt Lake City, UT, July 1, 2004 – June 30, 2008.

Associate Professor (Clinical Track) and Director of Student Programs in Family Medicine, Department of Family and Preventive Medicine, School of Medicine, University of Utah, Salt Lake City, UT, December 19, 1994 – June 30, 2004. Also, the first holder of the T.H.F. Morton, MD Endowed Chair in Family Medicine, 1994 - 2000.

Associate Clinical Professor, Department of Family Medicine, School of Medicine, University of Colorado Health Sciences Center, Denver, CO., December 1, 1992 - November 18, 1994.

Assistant Clinical Professor, Department of Preventive Medicine and Biometrics, School of Medicine, University of Colorado Health Sciences Center, Denver, CO., March 1, 1992 - November 18, 1994.

Assistant Clinical Professor, Department of Family Medicine, School of Medicine, University of Colorado Health Sciences Center, Denver, CO., August 1, 1987 - November 30, 1992.

Clinical Assistant Professor, Department of Community and Family Medicine, School of Medicine, Georgetown University, Washington, D.C., February 1, 1985 - April 15, 1987.

Clinical Instructor, Department of Family Practice, School of Medicine, University of California, Davis, CA., January 1, 1980 - July 1, 1982.

Clinical Teaching Faculty Appointment, Division of Ambulatory and Community Medicine, Department of Medicine, University of California School of Medicine, San Francisco, CA., 1978 - 1982.

Assistant Clinical Professor, Division of Family and Community Medicine, School of Medicine, University of California, San Francisco, CA., September 1, 1982 - February 10, 1984.

Clinical Instructor in Family, Community, and Preventive Medicine, Stanford University School of Medicine, Stanford, CA., April 1, 1979 - August 31, 1980.

Preceptor for clinical preceptorships in Family Practice at the Russian River Health Center, Inc., for medical students and Family Practice residents.

Preceptor for the Family Nurse Practitioner training program, California State College at Sonoma, Rohnert Park, CA., 1974 - 1982.

Clinical Instructor, Family Practice Residency Program, Community Hospital of Sonoma County, Santa Rosa, CA., July 1976 - February 1984.

Preceptor for the Primary Care Associate Program, Stanford University, Palo Alto, CA., 1979 - 1980.

Preceptor for the FNP - PA Training Program, University of California, Davis, CA., 1979 - 1981.

Supervising Physician for a Family Nurse Practitioner engaged in the Experimental Health Manpower Prescribing Project (the A.B. 717 project in California). Project was completed on July 1, 1983.

PROFESSIONAL ACTIVITIES

Summer Preceptee - Medical Student Preceptorship in General Practice, sponsored by the California Academy of General Practice (now known as the California Academy of Family Physicians), for two weeks, Summer - 1970.

Member of the Medical School Admissions Committee at the University of California School of Medicine, San Francisco, Fall 1969 - Spring 1972.

Resident member of the Board of Directors of the California Academy of Family Physicians, 1973 - 1974.

Family Practice Resident representative on the California Health Manpower Policy Commission, March 1974 - June 1977.

Member of the Board of Directors of the Sonoma County Branch of the American Heart Association of the Redwood Empire, 1977.

Member of the Board of Directors of the Sonoma County Coordinated Home Health Care Agency, 1977 - 1980.

Member of the Board of Directors of the Russian River Health Center, Inc., serving as the Administrator from March 1977 to July 1982, and Medical Director from March 1977 to August 1983.

Member of the Board of Medical Quality Assurance, Division of Allied Health Professions, February 1978 - June 1982. Offices held: Board Vice-President - 1980, Division Vice-President - 1980, Division President - 1981, Board Vice-President - 1982.

Chairman of the Physician's Assistant Examining Committee of the State of California, September 1978 - December 1980; and March 1981 - June 1982.

Member, National Health Service Corps, Coordination and Education Program Planning Committee for the Statewide Area Health Education Center system, northern California, 1979 - 1980.

Member of the Task Force on Physician's Assistants and Nurse Practitioners of the California Academy of Family Physicians, 1980 - 1981.

Member of the Commission on Health Manpower, California Medical Association, 1981 - 1984.

Member of the Resident Selection Committee, Family Practice Residency Training Program, Community Hospital of Sonoma County, Santa Rosa, CA., 1977 - 1981, and 1983.

Member of the District III Medical Quality Review Committee, California Board of Medical Quality Assurance, 1983 - 1984.

Chairman, Family Practice Department, Community Hospital of Sonoma County, Santa Rosa, CA., 1983.

Member, Disaster Medical Assistance Team, HRSA Clearing-Staging Unit, Rockville, MD., Alternate Team Leader 1984 -'85, Team Leader 1985 -'86, Deputy Unit Commander January 1986 - May 1987.

Interviewer for the Admissions Committee of the Uniformed Services University of Health Sciences School of Medicine, Bethesda, MD., 1984-1985, 1985-1986 and 1986-1987.

Member of the Membership and Member Services Committee of the Uniformed Services Academy of Family Physicians, 1985 - 1994.

Member of the Training, Awards and Recognition Workgroup of the Surgeon General's Revitalization Task Force for the Commissioned Corps of the U.S. Public Health Service, 1987.

Member of the Clinical Leadership Task Force of the State of Colorado, Department of Health, established as part of the Cooperative Agreement between the PHS/HRSA and the State of Colorado, 1987 - 1989.

Delegate to the Commissioned Officers Association House of Delegates meeting representing the Rocky Mountain Chapter of the U.S. Public Health Service Professional Association, held in Scottsdale, AZ., 1988.

President of the Rocky Mountain Chapter of the U.S. Public Health Service Professional Association, 1988/89.

Member of the Board of Directors of the Uniformed Services Academy of Family Physicians (a chapter of the AAFP), 1988 – 1993. (First PHS officer to serve on the Board.)

Member of the Committee on Members' AAFP Insurance & Financial Services, of the American Academy of Family Physicians, appointed for 1988, reappointed for 1989, reappointed for 1990.

Part-time, temporary family practice physician with the Colorado Permanente Medical Group, P.C., doing patient care for their Urgent Care Centers (in Lakewood and at the Special Care Center in Denver), December 1988 to March 1990.

Member of the Committee on Community Health Services of the Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Public Health Service; February 1989 - December 1990.

Member of the Board of Directors of the Uniformed Services Academy of Family Physicians Foundation, 1991 - 1994 (first PHS officer to serve on the Board), elected as the first President of the Foundation, February 1992 - 1994.

Temporary duty assignment to New Iberia, LA., to provide medical assistance in the aftermath of Hurricane Andrew, November 1992.

Member of the Conference Series Program Committee for the Western and Rocky Mountain STFM Annual Meetings, 1993 - 1995.

Faculty Advisor, Family Medicine Interest Group, School of Medicine, University of Utah, Salt Lake City, UT, January 1995 – June 2008.

Member, LCME Accreditation Steering Committee, School of Medicine, University of Utah, Salt Lake City, UT, June 1995 - October 1996.

Member of the Utah AHEC Advisory Board and Executive Committee, 1995 – 1999. Associate Director for Education, June 1995 – July 2000. Senior Associate Director, July 2000 – June 2008.

Member, Third Year Curriculum Committee and Third Year Promotions Committee, School of Medicine, University of Utah, Salt Lake City, UT, July 1995 – January 2008.

Faculty Advisor for the senior Honors program in Family Medicine, July 1995 – June 2008.

Member of the Board of Directors of the Utah Academy of Family Physicians, representing medical student programs at the University of Utah, January 1996 – present, President-Elect for 2000, President for 2001, Past-President for 2002, Treasurer for 2004-10.

Member of the Physicians Licensing Board, Division of Occupational and Professional Licensing, Department of Commerce, State of Utah, July 1, 1996 – June 2001.

Member of the Physician Assistant Licensing Board, Division of Occupational and Professional Licensing, Department of Commerce, State of Utah, July 1, 1996 – June 2001 (Chairman for 1997 - 2001).

Faculty Advisor, Rural Medicine Interest Group, School of Medicine, University of Utah, Salt Lake City, UT, July 1996 – June 2008.

Developed a curriculum (a four lecture series) on Health Care Delivery Systems for the Utah Physician Assistant Program, presented during academic years 1996 – present.

Faculty Advisor, Health Care for the Homeless Clinic Students, School of Medicine, University of Utah, Salt Lake City, UT, January 1997 – June 2008.

Member of the State Advisory Committee for the Provider Enrichment Program of the Association for Utah Community Health, funded by a demonstration grant from the National Health Service Corps, March 1997 - 2000.

Member (by gubernatorial appointment) of the Special Population Provider Financial Assistance Committee, as the urban representative of the Association for Utah Community Health, for a four year term ending October 1, 2001. Elected Chairman for 1997-1999.

Delegate to the Utah Medical Association, representing the Utah Academy of Family Physicians, 1998 - 2000, 2002 – 2011; representing the Board of Trustees, 2012 – present.

Member of the Utah Department of Health's Primary Care Needs Assessment Committee, January 1999 – 2000. Committee provides oversight and guidance to Health Department staff as they develop and perform a statewide needs assessment for primary health care services.

Member, Advisory Group for the "Promoting, Reinforcing, and Improving Medical Education (PRIME) project, sponsored by the Division of Medicine, BHPr/HRSA/PHS/DHHS, under contract to the American Medical Student Association, January 1999 – 2003.

Member, Fourth Year Curriculum Committee and Fourth Year Promotions Committee, School of Medicine, University of Utah, Salt Lake City, UT, July 2000 – January 2008.

Member, Service-Learning Advisory Board, Bennion Center, University of Utah, representing the School of Medicine, Salt Lake City, UT, 2000 – 2008 (Chair, 2004 – 2008).
Member – Class Committee, 2000 – 2004.

Member – Faculty Committee, 2004 – 2008 (Chair, 2004 - 2008).

Member, Clinical Faculty Review Committee, Department of Family and Preventive Medicine, University of Utah SOM, 2002.

Member (by gubernatorial appointment) of the Utah Health Care Workforce Financial Assistance Program Advisory Committee, from December 1, 2002 – May 1, 2005. Elected Chairman for 2003-4.

Project Director, for "Achieving Diversity in Dentistry and Medicine," a project funded by the Health Resources and Services Administration through a contract with the American Medical Student Association Foundation, from October 1, 2003 – July 2008.

Member of the Physicians Licensing Board, Division of Occupational and Professional Licensing, Department of Commerce, State of Utah, July 1, 2004 – June 30, 2008, reappointed for July 1, 2008 – September 21, 2012 (Chair from July 2008 – July 2009).

President-Elect, Salt Lake County Medical Association, December 2004 – November 2005.

Member of the Board of Directors of the Utah Academy of Family Physicians Foundation, November 2005 - present, elected as President of the Foundation, November 2005 - present.

President, Salt Lake County Medical Society, December 2005 – November 2006.

Past-President, Salt Lake County Medical Society, December 2006 – November 2007.

Member, Board of Directors, Lowell Bennion Community Service Center, University of Utah, Spring 2007 – June 2009.

Physician Reviewer for HRSA (Health Resources and Services Administration) of Federal Tort Claims actions against covered primary care providers; 2010 – 2018.

Member, Board of Directors, Salt Lake Community Health Centers, Inc., Summer 2008 – April 2010.

Member, Board of Directors, Midvale Family Health Center, February 2009 – April 2010.

Chair, Refugee Health Advisory Committee for Utah's Refugee Advisory Board, February 2009 – 2011.

Speaker of the House of Delegates for the Utah Medical Association, elected at the 2012 session, re-elected at the 2014 session; September 2012 – 2016. In this role, also serve on the Board of Trustees and the Executive Committee of the Utah Medical Association; September 2012 – 2016.

Educational Consultant to Utah Medical Association for the production of an online, 3.5 hour, 6-module CME course titled “Controlled Substances, Education for the Prescriber.” I reviewed and edited content and organization, developed patient case studies, and developed the required exams at the conclusion of each module. Fall 2013.

Member, Utah’s Multi-Cultural Commission, July 2015 – 2020.

Contracted Consultant with the Office of the Legislative Auditor General for Utah to assist with their audit of healthcare in the state prison system. August-September 2021.

PUBLICATIONS: Journals

"Family Practice Residency-Community Clinic Linkages for Physician Exchange," The Journal of Family Practice, Vol. 12, No. 2: 361-363, 1981, Jonathan E. Rodnick and Marc Babitz.

"Teaching Longitudinal Care Without Patients," Family Medicine, Vol. XVI, No. 6: 229-230, 1984; Marc E. Babitz, M.D.; Jonathan E. Rodnick, M.D.; and Rick Flinders, M.D.

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“Community Oriented Primary Care (COPC): An Effective Paradigm for Preventive Care,” Utah’s Health, An Annual Review, Vol. VII:11-16, 2000-2001; M.E. Babitz, M.D., F.M. Bishop, Ph.D., M.S.P.H.

“Integrating Public Health into Medical Education: Community Health Projects in a Primary Care Preceptorship,” Academic Medicine, Vol. 76:No. 10: 1076-1079, 2001; M.K. Magill, MD, R. Quinn, MPA, M. Babitz, MD, S. Saffel-Shrier, MS, RD, S. Shomaker, MD, JD.

“Combining Medical Education and Service,” Physicians Practice Digest, Vol. 11:No. 6: A1-A2, 2001; M. Babitz, MD.

"An Assessment of the Health Background, Status, and Care Utilization of the Sudanese Youth "Lost Boys" Population in Salt Lake City," Utah's Health: An Annual Review, Vol. IX:46-51, 2003; R. Thompson, BA, M.E. Babitz, M.D.

"Mutual Respect in Healthcare: Assessing Cultural Competence for the University of Utah Interdisciplinary Health Sciences," Journal of Allied Health, Summer 2009, Vol. 38, No. 2:54-62; GM Musolino, PT, MSEd, EdD; M Babitz, MD; ST Burkhalter; C Thompson, MStat; R Harris, MD, MBA; RS Ward, PT, PhD; S Chase-Cantarini, RN.

"Understanding and Eliminating Disparities in Health Care: Development and Assessment of Cultural Competence for Interdisciplinary Health Professionals at the University of Utah – a 3-year Investigation, " Journal of Physical Therapy Education, Winter 2010, Vol. 24, No. 1:25-36; GM Musolino, PT, MSEd, EdD; ST Burkhalter; B Crookston, MPH; RS Ward, PT, PhD; RM Harris, MD, MBA; S Chase-Canatarini, RN, MS; M Babitz, MD.

"Commentary: The PCP Perspective on Urine Drug Testing: An Underused Tool," Pain Management Today eNewsletter series, Vol. 1, Issue 7, February 2011, sponsored by the Journal of Family Practice; M Babitz, MD.

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Haberberger, R. and Babitz, M.E. National Health Service Corps physician continuing education survey. USPHS Professional A. Ann. Meeting, Program Abstr., 20:48, April 9-12, 1985.

Babitz, M., Wells, J., and Smith, D. Community Oriented Primary Care As Practiced In Federally Funded Community Health Centers. USPHS Professional A. Ann. Meeting, Program Abstr., 23:30-1, May 22-25, 1988.

Burnett, W.H. and Babitz, M.E. The Family Practice Movement and the United States Public Health Service: Introducing Care to the Underserved at the Predoctoral Level. STFM 1990 Ann. Predoctoral Education Conference, Program Abstr., February 1 - 4, 1990.

Chung, C., LoGiudice, F., Levesque, R., and Babitz, M. Live Life Litely Program. USPHS Professional A. Ann. Meeting, Program Abstr., 26:67, May 26-29, 1991.

Clark, C. and Babitz, M., Embedding the Teaching of a Community-Based Research Model Within a Service-Learning Course for Fourth Year Medical Students: How To Do It. Did They Learn It? 3rd Annual International K-H Service-Learning Research Conference, Program Abstract, November 6-8, 2003.

Babitz, M., Clark, C., Stewart, M. An Electronic, Virtual Community to Teach Community Oriented Primary Care. Association of American Medical Colleges Annual Meeting, GEA Session, Program Abstr., November 7 – 12, 2003.

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Dyer, J., Babitz, M. Nurse Practitioners, Nurse Midwives and Physicians – Effective Rural Health Care Teams. NRHA 2004 Ann. Conf., Program Abstr., May 27 – 29, 2004.
Babitz, M; Clark, C; Stewart, M; An Electronic, Interactive, Virtual Community to Teach Community Oriented Primary Care. NRHA 20054 Ann. Conf., Program Abstr., May 19 – 22, 2004.

Musolino, G.; Harris, R.; Babitz, M.; Ward, S.; Chase-Cantarini, S.; Smith, Y.; Mutual Respect in Healthcare: Assessing Cultural Competence for the Interdisciplinary Health Sciences at the University of Utah. APTA Combined Sections meeting, Abstr., 2006.

Babitz, ME; Clark, C; Stewart, M and Cochella, S, An Electronic, Interactive, Virtual, Urban Community to Teach Community-Oriented Primary Care, STFM 33rd Ann. Predoctoral Education Conference, Program Abstracts, 2007.

Babitz, ME; Clark, C; Quinn, R, Teaching Public Health and Community Health Using a "COPC" Approach, STFM 34th Ann. Predoctoral Education Conference, Program Abstracts and Family Medicine Digital Resource Library, 2008.

Babitz, ME; Ipsen, S, Utah's Safety Net Initiative: Collaboration in the Care of the Underserved, ASTHO – NACCHO 2008 Conference, Program Abstracts/Poster Showcase Directory, September 2008.

PUBLICATIONS: Book Chapter

Babitz, M.E., "COPC: Doing Something Is Better Than Doing Nothing." In Nutting, PA (ed): Community-Oriented Primary Care: From Principle to Practice. HRSA publication No. HRS-A-PE 86-1, 1987. U.S. Government Printing Office, Washington, D.C.

PUBLICATIONS: Other

Babitz, M, Burnett, W, Berringer, B. A comprehensive manpower strategy for the Public Health Service: a working document. In: Proposed Strategies for Fulfilling Primary Care Manpower Needs. Rockville, MD: National Health Service Corps: 1990:appendix A.

"Community Oriented Primary Care," a 56 minute, educational videotape presentation by Marc E. Babitz, M.D., produced by JSI Research & Training Institute under contract with the National Health Service Corps, September 1993.

"Continuous Quality Improvement in Health Care," Practice Management Guide, A Supplement to Physician Assistant, 5-9, September 1993; Marc E. Babitz, M.D.

Magill, M.K., Babitz, M.E. and Silver, M.P., Letter to the Editor. Corresp. N Engl J Med 1996; 335:896.

"Continuous Quality Improvement," a series of 6 educational videotapes (approximately 40 minutes each) by Marc E. Babitz, M.D. and Les Wallace, Ph.D., produced by the Community Health Association of the Mountain/Plains States, under contract with the U.S. Public Health Service, Region VIII, Winter 1996 - 1997.

"Practicing with a Physician Assistant: A Physician's Perspective," Utah Medical Association's bulletin, Vol. 47/No.1:January 1999, Marc Babitz, MD.

"Quality assurance: myth, reality or law?" Utah Medical Association's bulletin, Vol. 47/No. 12:December 1999, Marc Babitz, MD.

"Coordination with the Community," "Coordination with Colleagues," and "Coordination of Referral Arrangements," a series of featured interviews in The Healthcare Collaborator newsletter, November 2000, Marc Babitz, MD.

PUBLICATIONS: Educational Software

"Caring for a Community: Learning the Process of Community Oriented Primary Care," an interactive, educational, computer software program on a CD-ROM that utilizes a "virtual" rural community in which the user can learn and practice community oriented primary care from Needs Assessment, to Prioritization, to Intervention, through Summary and Evaluation. Introduced in June 2004, authored by Marc Babitz, MD and Claire Clark, PhD.

"An Introduction to Public Health," an educational, computer software program on a CD-ROM, that provides users with an introduction and overview of Public Health. Introduced in August 2004, authored by Marc Babitz, MD.

"Caring for a Community: Learning the Process of Community Oriented Primary Care," an interactive, educational, computer software program on a CD-ROM that utilizes a "virtual" urban, multi-cultural community in which the user can learn and practice community oriented primary care from Needs Assessment, to Prioritization, to Intervention, through Summary and Evaluation. Introduced in June 2008, authored by Marc Babitz, MD.

POSTERS:

PHS Experience Prepares Faculty to Teach Cross-Cultural Health Care, a poster by Marc E. Babitz, MD and Larry Li, MD, MSPH, for the National Health Service Corps' 25th Anniversary Conference, April 24 – 26, 1998, Washington, D.C. Also presented at the NHSC Annual Conference series for 1999: Las Vegas, October 7 – 9, and Orlando, November 3 – 5; and 2000: McClean, April 6 – 8, San Jose, November 16 – 18, and Orlando, December 7 - 9.

Social Factors in Rural Pneumonia Hospitalizations, a summer research project by Sean Paulsen and Gregory Daynes (MS IIs), coordinated by Marlene Egger, Ph.D., Mike Magill, M.D., and myself. Presented at the Annual Meeting of the Society of Teachers of Family Medicine, April 1998.

The Virtual Community – An Innovative Approach to Teaching C.O.P.C., a poster by Student Programs in Family Medicine, DFPM, for the 29th Annual Predoctoral Education Conference of the Society of Teachers of Family Medicine, Austin, TX, January 2003.

An Electronic, Virtual Community to Teach Community-Oriented Primary Care, a poster by Student Programs in Family Medicine, DFPM, for the Association of American Medical Colleges Annual Meeting, Washington, D.C., November 2003.

An Electronic, Virtual Community to Teach Community-Oriented Primary Care, a poster by Student Programs in Family Medicine, DFPM, for the 30th Annual Predoctoral Education Conference of the Society of Teachers of Family Medicine, New Orleans, LA, January – February 2004.

Utah's Safety Net Initiative: Collaboration in the Care of the Underserved, a poster by the Division of Health Systems Improvement, Utah Department of Health, for the 2008 ASTHO -NACCHO meeting, Sacramento, CA, September 9 – 12, 2008.

INVITED,UNIVERSITY GUEST LECTURESHIPS

"Community Oriented Primary Care," presented at the Robert Wood Johnson University of Medicine and Dentistry of New Jersey, June 10, 1998, in New Brunswick, NJ. Audience included medical students, family practice residents and faculty from the Department of Family Medicine.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the University of Nebraska School of Medicine, August 26, 1998, in Omaha, NE. Presented to the second-year medical school class and selected faculty as the lead presentation for their Integrated Clinical Experience curriculum.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the Indiana University School of Medicine, December 7, 1998, in Indianapolis, IN. Presented to the third-year medical school class as part of a series on Current Issues in Medicine.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the University of Nebraska School of Medicine, August 26, 1999, in Omaha, NE. Presented to the second-year medical school class as the lead presentation for their Integrated Clinical Experience curriculum.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the University of Nebraska School of Medicine, August 30, 2000, in Omaha, NE. Presented to the second-year medical school class as the lead presentation for their Integrated Clinical Experience curriculum.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the University of Nebraska School of Medicine, August 30, 2001, in Omaha, NE. Presented to the second-year medical school class as the lead presentation for their Integrated Clinical Experience curriculum.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the University of Nebraska School of Medicine, August 28, 2002, in Omaha, NE. Presented to the second-year medical school class as the lead presentation for their Integrated Clinical Experience curriculum.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the University of Nebraska School of Medicine, August 28, 2003, in Omaha, NE. Presented to the second-year medical school class as the lead presentation for their Integrated Clinical Experience curriculum.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the St. Louis University School of Medicine, March 8, 2004, in St. Louis, MO. Presented to the first-year medical school class as part of their Physician, Patient and Society course.

"Caring for the Patient Who's Not in the Room, Community Oriented Primary Care," presented at the University of Nebraska School of Medicine, August 25, 2004, in Omaha, NE. Presented to the second-year medical school class as the lead presentation for their Integrated Clinical Experience curriculum.

OTHER INVITED PRESENTATIONS

"Is There Nothing More That I Can Do." Keynote presentation for the Advanced Care Planning Conference, held virtually, November 10, 2020. Conference sponsored by Comagine and the Utah Commission on Aging.

GRANTS RECEIVED

Pre-Doctoral Training Grant, from the Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration, Public Health Service/DHHS; for $130,000 (+ 8% indirect) per year for three years, July 1, 1996 - June 30, 1999.

1996-1997 Faculty Enhancement Award from the Society of Teachers of Family Medicine to study curriculum reform at the Oregon Health Sciences University and its impact on their Department of Family Medicine. Awarded $2,000 to offset travel and per diem expenses.

Health Research Center Semi-Annual Grant Award, Department of Family and Preventive Medicine, University of Utah, with Marlene Egger, Ph.D., to study Physician Variables in the Decision to Admit to the Hospital, Fall 1996 - Spring 1997.

Intermountain Health Care Student Programs Grant, to support family medicine clerkships and preceptorships in rural sites (including funds for faculty, staff and student travel stipends). Awarded $160,000 for 1997 and 1998. Awarded $120,000 for 1999. Awarded $80,000 for 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007 and 2008. (This was an ongoing grant to the Department since 1992).

Pre-Doctoral Training Grant, from the Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration, Public Health Service/DHHS; for three years, July 1, 2001 - June 30, 2004, for $120,809 (+ 8% indirect) in year one, and $114,329 per year in years two and three.

Pre-Doctoral Training Grant, from the Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration, Public Health Service/DHHS; for three years, July 1, 2005 - June 30, 2008, for $111,100 (+ 8% indirect) in year one, $99,085 (+ 8% indirect) in year two, (final year of funding dependent on level of congressional appropriations).

PROFESSIONAL PRESENTATIONS

I have made several hundred public presentations to local, regional, and national organizations during the course of my professional career. Many of these have been part of accredited continuing medical education programs. The majority of these presentations were made while I was an officer in the Public Health Service or as faculty of the University of Utah; however, others have been made as a private individual. The following list notes the topics of presentations made in recent years:

Community Oriented Primary Care/Caring for the Patient Who's Not in the Room (Presented as the Opening Keynote session for the American College of Nurse Practitioners Annual Meeting; October 18, 2001; Atlanta, GA.).
Nurse Practitioners, Nurse Midwives and Physicians - Effective Rural Health Care Teams
The Practical Application of Community-Oriented Primary Care (COPC) Theory by FP Residency Programs
Continuous Quality Improvement
Cultural Competence in Health Care/Cultural Diversity in Health Care
The Male Genital Exam (designed for providers in STD clinics)
Clinical Prevention in Family Practice
Shared Leadership in Health Care
Practice Management for New Health Care Providers
The State of Health Care in America

Quality Assurance in Ambulatory Care Settings
Rural Health Care
Clinical Leadership: Roles and Skills
Health Care Issues for Homeless and Migrant Families
Developing and Implementing Health Care Plans
Preventive Health Care Schedules
Health Needs Assessment
Improving Patient Compliance
Recruitment and Retention for Underserved Communities
Contracting Issues for Health Professionals
The Role of the Health Services (Clinical) Director
The Organization and Functions of the Public Health Service
The Meaning of Service in the Health Professions (to Pharmacy students)
Access to Health Care (to PH students)
Health Professions Workforce Issues (to PH students)
Patients I Have Known: And, What They Taught Me

PROFESSIONAL SOCIETY MEMBERSHIPS

American Academy of Family Physicians

Utah Academy of Family Physicians (President-elect for 2000, President for 2001, Past-President for 2002, Treasurer 2004 - 2010), Foundation member and President 2005 – 2020.

Uniformed Services Academy of Family Physicians (adjunct member)

Utah Medical Association (Ex-Officio member Board of Trustees, representing UDOH, 2011 - 2012; elected as Speaker of the House of Delegates and official member of the Board of Directors and the Executive Committee, 2012 – 2016; ex officio member of the Council of Trustees representing the Utah Department of Health, 2016 - 2020).

Salt Lake County Medical Association (President-Elect 2004 - 2005, President 2005 – 2006, Past-President 2006 - 2007).

Commissioned Officers Association of the U.S. Public Health Service, 1984-2014.

Gold-Headed Cane Society, University of California, San Francisco, 1972 – present.

HOSPITAL STAFF MEMBERSHIPS

Current

Salt Lake Regional Medical Center, Salt Lake City, UT, Active Staff, 1995 – 2004, Courtesy Staff, 2005 - present.

Primary Children’s Medical Center, Salt Lake City, UT, Active Staff, 1996 – 2004, Active Referral Staff, 2005 - present.

Past

LDS Hospital, Salt Lake City, UT, Courtesy Staff, Fall 1996 - 2010.

Intermountain Medical Center, Murray, UT, Courtesy Staff, Fall 2007 – 2010.

University Hospital, University of Utah Health Sciences Center, Salt Lake City, UT, Active Staff, 1995 – 2008.

Community Hospital of Sonoma County, Santa Rosa, CA., Active Staff, 1976 - 1984.

Palm Drive Hospital, Sebastopol, CA., Courtesy Staff, 1976 - 1984.
Healdsburg General Hospital, Healdsburg, CA., Courtesy Staff 1981 - 1984.

REFERENCES - Available on request.

Agency Response

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Utah Department of Corrections
Executive Office

BRIAN NIELSON
Executive Director

Audit Response

November 29, 2021

Kade R. Minchey CIA, CFE, Auditor General
Office of the Legislative Auditor General Utah State Capitol Complex
Rebecca Lockhart House Building, Suite W315
P.O. Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Minchey,

Thank you for the opportunity to respond to the recommendations in *A Performance Audit of Healthcare in State Prisons* (Report #2021-17). We appreciate the effort and professionalism of you and your staff in this review and the collaboration needed from our staff to provide requested information, answer questions, and plan changes to improve health care in our state correctional facilities. We believe that the results of our combined efforts will ensure improved healthcare in Utah's prisons. We concur with all recommendations in this report and have outlined our actions and timelines to demonstrate our agreement. Our teams in the Clinical Services Bureau (CSB), operational excellence, data, Internal Audit, legislative and stakeholder relations, and communications are mobilized to partner on actions to assist the Legislature in their decisions on behalf of those we serve. The Department of Corrections is committed to efficient operational processes, effective use of taxpayer funds, and quality patient healthcare. We value the insight this report provides on areas that can be improved.

Sincerely,

Brian Nielson, Executive Director

CHAPTER II

Recommendation 2.1. We recommend that the executive director of the Department of Corrections ensure that all recommendations in this audit are adequately implemented.

Department Response: The Department concurs.

What: The executive director will continually monitor and ensure the implementation of all recommendations in this audit, many of which have already occurred or are in the process of occurring.

How: The director of CSB will report through the deputy executive director over CSB, through weekly meetings. The deputy executive director will update the executive director monthly.

When: The weekly updates have already begun. The monthly updates will begin on January 3, 2022.

Contact: Chyleen Richey, Deputy Executive Director, crichey@utah.gov, 385-695-0677

Recommendation 2.2. We also recommend that the executive director of the Department of Corrections launch an internal review to determine if additional changes not addressed in this report are needed regarding operations and/or staff.

Department Response: The Department concurs.

What: The Internal Audit Bureau (IAB) will include this in its development of the next year's audit plan.

How: IAB will conduct a risk-based audit after careful consideration of this legislative audit. IAB will look at all areas of clinical services to determine if any additional changes may be beneficial to the Department.

When: Completed by December 2022

Contact: Rachel Summers, Internal Audit Director, rlsummers@utah.gov, 385-529-6966

Recommendation 2.3. We recommend that the Clinical Services Bureau ensure providers and other medical staff define the term "monitor" in patient charts with specific parameters on a case-by-case basis.

Department Response: The Department concurs.

What: The Department has purchased a new Electronic Health Record (EHR) System (Fusion).

How: The new system has additional capabilities which will allow a provider or other medical staff to check boxes for more focused follow up and monitoring, thereby eliminating vague follow-up recommendations. Each chronic care category will auto-populate templated follow-up needs according to diagnosis.

When: Fully operational by March 2022 (proposed date)

Contact: Dr. Darrel Olsen, Clinical Director, darrelolsen@utah.gov, 801-380-7880

Recommendation 2.4. We recommend that the Clinical Services Bureau increase oversight to ensure appropriate case-by-case patient follow up procedures are being completed.

Department Response: The Department concurs.

What: Continuous Quality Improvement (CQI) system

How: The CQI committee will follow a random sample of inmate cases reviewed on a monthly basis to ensure appropriate case-by-case patient follow up. Lack of appropriate follow-up and corrective action will be addressed with the specific provider by the Clinical Director.

When: January 2022

Contact: Bobbi Brown, Senior RN (CQI Manager) bobbibrown@utah.gov, 435 528-6081

Recommendation 2.5. We recommend that the Clinical Services Bureau ensure that all patients have access to:

- **Appropriate and timely clinical judgements rendered by a qualified healthcare professional.**
- **Correct treatments and medications for corresponding diagnoses.**

Department Response: The Department concurs.

What: Continuous Quality Control (CQI) system

How: The CQI committee during the previously mentioned monthly reviews will determine if clinical assessments are timely and appropriate. They will also review recommendations for outside treatments and medications requested. Lack of appropriate and timely care or failure to follow recommendations (or document otherwise) will be addressed with the specific provider by the Clinical Director.

When: January 2022

Contact: Bobbi Brown, Senior RN (CQI Manager) bobbibrown@utah.gov, 435 528-6081

Recommendation 2.6. We recommend that the Clinical Services Bureau follow internal policies and professionally recognized standards regarding the administration of insulin and oversight of inmates with diabetes.

Department Response: The Department concurs. However, we would like to clarify that all diabetics in general population have access to a glucometer to monitor blood sugars at any time. In high security areas, glucometers are available at pill lines for inmate testing, and in some instances, additional pill line access is provided based on inmate need.

What: Monthly Chronic Care team (senior RNs) reviews

How: The Chronic Care team will conduct monthly meetings reviewing medical standards in comparison to diabetes management protocols for a random sample of diabetic inmates, which will be documented and maintained at the Bureau level for CQI review.

When: January 2022

Contact: Adam Archer, Senior RN, aarcher@utah.gov, 801 576-7290

Recommendation 2.7. We recommend that the Clinical Services Bureau create policies and procedures to effectively manage nutrition and medical care for diabetic patients during disruptions or delays to the normal schedule.

Department Response: The Department concurs.

What: Addition to CSB policy manual (formerly Technical Manual)

How: CSB will add a section to its internal policy addressing managing disruptions or delays for chronic care health needs, as well as nutrition management.

When: February 2022

Contact: Jane Reed, Records Manager, janereed@utah.gov, 801 576-7124

Recommendation 2.8. We recommend that the Clinical Services Bureau develop policies where appropriate that help the organization be more compliant with CDC standards regarding medical issues such as the COVID-19 pandemic.

Department Response: The Department concurs.

What: Addition to CSB policy manual (formerly Technical Manual)

How: CSB will add a section to its internal policy addressing infectious disease processes, by adding guidance on handling pandemics based upon lessons learned.

When: February 2022

Contact: Jane Reed, Records Manager, janereed@utah.gov., 801 576-7124

CHAPTER III

Recommendation 3.1. We recommend that the Clinical Services Bureau ensure that the use of emergency medical technicians in the prison is consistent with state statutes and best practices, and that licensed nurses (or other qualified medical professionals) are used in situations that require a level of skill and knowledge beyond what an EMT is certified for.

Department Response: The Department concurs.

What: Legal review

How: The Department has requested that its legal counsel at the Utah Attorney General's Office review the Utah State Prison's utilization of EMTs, including the prison's use of EMTs to deliver inmate medications, to ensure it is not inconsistent with state or federal law or NCCHC standards. If the Department's utilization of EMTs is found to be inconsistent with applicable laws or standards, CSB will adjust its practices to come into compliance.

When: Immediately

Contact: Colleen Guymon, Deputy Director, colleenguymon@utah.gov, 801 576-7110

Recommendation 3.2. We recommend that executive management at the Department of Corrections ensure that personnel in the Clinical Services Bureau fully comply with NCCHC standards.

Department Response: The Department concurs.

What: 1) Tracking assessment data, 2) ICR face-to-face encounters with qualified health professionals, and 3) medication disposal.

1. The data used to reach the health, mental health, and dental assessment conclusions has many nuances that cannot be adequately captured by the aggregate analysis.
    a. Initial Health Assessment - All inmates receive an intake screening upon entry to the prison. The data used in this section refers to a follow-up physical examination which is to be completed within 7 days by NCCHC standard. To provide perspective, this is a 98.4% success rate over the three year period. Some explanation to account for some of the missing exam data includes:
        i. When an inmate received an initial health assessment in a county jail prior to being transferred to prison.
        ii. During 2018 and 2019, when an inmate had returned to prison within 6 months, the former policy was to not complete a new physical exam unless something was discovered during the intake health screenings.
    b. Mental Health Intakes - All inmates receive a mental health screening upon entry to prison. The data used in this section refers to follow-up mental health evaluations required when a mental health issue is flagged during the intake screening to be completed within a 30-day time frame. Of the 143 mental health evaluations reported as not completed, during a brief spot check of a small number of cases, we found 17 that were completed within the time frame. This was due to variations in how the information was entered in Mtrack, which could not be captured by the data aggregation method, i.e they were entered as a note instead of in the exam data field.
        i. The average MH evaluation completion rate for males in the 3 year period was 97%.
        ii. The average MH evaluation completion rate for females in the 2 year period was 96%. (Data from 2018 was not requested)
        iii. In the mental health data there was no mention of how many days past the standard were encompassed in the findings.
    c. Dental Examinations - The vast majority of the missing dental examinations to be completed within 30 days occurred in 2020 when there was an order in place outlining that dental exams were routine and not a priority during the pandemic outbreak and we were strongly advised to delay these examinations.
        i. Dental Examination completion within 30 days 2018 - 99.82%
        ii. Dental Examination completion within 30 days 2019 - 100%
        iii. Dental Examination completion within 30 days 2020 - 77%
        iv. In the dental data there was no mention of how many days past the standard were encompassed in the findings.

<u>How:</u>

1. CSB will review how this data is collected and collated so that the Department can more easily and accurately determine its compliance with required standards.
2. CSB is in the process of ensuring all ICRs submitted are accompanied by a face-to-face encounter with a qualified health professional. All nursing staff will receive training on the standard for reviewing, which may occur during pill lines as well. Face-to-face encounters will occur within 24 hours.

3. All EMTs and other staff associated with medication delivery will receive quarterly training on proper medication disposal with the requirement being added to each staff's UPM.

When:

1. In the short term, before March of 2022, CSB management will review the data collection and collation to determine improvements that can be made through existing technology. In the long term, beginning March of 2022 and beyond, the Electronic Health Record System (currently being developed) will resolve this difficulty of tracking compliance.
2. Face-to-face encounters regarding ICRs has already been initiated and will be fully implemented by January 2022.
3. Medication disposal training has been implemented and is scheduled to occur on a quarterly basis.

Contact: Chyleen Richey, Deputy Executive Director, crichey@utah.gov, 385-695-0677

Recommendation 3.3. We recommend that the Clinical Services Bureau ensure compliance with statute regarding the protection of personal health information.

Department Response: The Department concurs.

What: Mandatory Quarterly Training for medication delivery staff

How: CSB will conduct and document mandatory quarterly training regarding protecting personal health information. This training requirement will be added to the Utah Performance Management System.

When: Quarterly training will begin in March 2022

Contact: Eric Difrancesco, RN, DON, edifranc@utah.gov, 385 224-3201

Recommendation 3.4. We recommend that the Clinical Services Bureau follow the inmate handbook regarding copays for mental health services.

Department Response: The Department concurs.

What: While the Department has statutory authority to collect a $5 copay for medical services, when an inmate has assets exceeding $200,000, the statute requires that inmate to pay up to 20% of the inmate's total asset value. CSB made the decision to publish in the inmate handbook that there would be no copay for mental health services in order to remove any real or perceived barrier to accessing mental health services. However, CSB collected copays on several

inmates. While it technically had the authority to do so, it was inconsistent with its messaging and intent.

How: CSB immediately stopped charging mental health copays when this inconsistency was brought to its attention by the auditors.

When: October 2021

Contact: Chyleen Richey, Deputy Executive Director, crichey@utah.gov, 385-695-0677

CHAPTER IV

Recommendation 4.1. We recommend that the Clinical Services Bureau follow *Utah Administrative Rule* when implementing incentive programs.

Department Response: The Department concurs.

What: CSB and DHRM will develop a process to monitor incentive awards. It is important to note that everyone received money that was appropriately intended by the Department. What is in dispute is the administrative method.

How: Incentive awards for RN overtime have been modified to be accounted for through shift differential. Bonus and Retention awards will be used sparingly and administered with DHRM oversight.

When: Immediately

Contact: Brooke Baker, HR Manager, bbaker@utah.gov, 385 258-7827

Recommendation 4.2. We recommend that the Clinical Services Bureau be transparent with the Legislature in how program funds are being used.

Department Response: The Department concurs.

What: The savings from unfilled FTE pins is used to fund medical services.

How: While this information is provided to the LFA, it is not specifically highlighted or expressly pointed out.

When: The Department will begin expressly pointing this out to the LFA this 2022 General Session and moving forward.

Contact: Chyleen Richey, Deputy Executive Director, crichey@utah.gov, 385-695-0677

Recommendation 4.3. We recommend that the Clinical Services Bureau create meaningful performance metrics that reflect program activity.

Department Response: The Department concurs. However, it is important to clarify that the 3-day closure goal is not a medical standard, but rather an internal efficiency goal intended to drive improvement over time. Healthcare is completed according to medical triage and need.

What: The 3-day closure performance measure reflects one aspect of the SUCCESS initiative, created by Gov. Herbert's GOMB. This measure was developed in close collaboration with that office. The 4-1 data tracking formula was designed to capture those requests that were closed in less than a day, as they can be entered at any time of day. When creating this performance measure, GOMB had difficulty finding a measure that could be improved by 25%, as CSB was already meeting their performance measures close to 100%. We have since been directed to re-evaluate these measures with Gov. Cox's new administration. The Department has been working on re-evaluating all Department measures since the beginning of this year and is committed to doing so in a way that collects and uses staff input.

How: CSB leadership began brainstorming and coordinating with the Department's Executive Office and Director of Operational Excellence prior to the beginning of this audit to generate measurements that aim to track the quality of medical services provided to our incarcerated population. These revisions, which began to take shape even prior to this audit, will align CSB more closely with the Department's goals and expectations, while also aligning with the recommendations of this audit and the Governor's office.

When: The development of these performance measures is in the final discussion stages, but it is important to solicit feedback from medical providers and CSB staff so that we have quality measures that are supported and understood by all staff. We intend to have the measure finalized and operationalized in January 2022.

Contact: Steve Gehrke, Director of Operational Excellence, sgehrke@utah.gov, 385-237-8040

Recommendation 4.4. We recommend that the Clinical Services Bureau ensure that formulary, procedures, policies, and training materials are all up to date.

Department Response: The Department concurs.

What: While the Department recognizes that some trainings and protocols are unlikely to change from year-to-year, we will implement a process to review training materials and protocols annually. In addition, we will continue quarterly Pharmacy and Therapeutics meetings to review medications.

How: CSB will compile all training material and develop an annual sign off, demonstrating that all training has been reviewed annually (though some training content will not change). In addition, formulary reviews that are conducted quarterly will be documented annually as reviewed, even if no changes are formally made.

When: March 2022

Contact: Wes Shuman, Senior RN, Training Manager, wshuman@utah.gov, 801-507-6537