STATE OF CALIFORNIA —DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

DIVISION OF ADULT INSTITUTIONS
MULE CREEK STATE PRISON
4001 HIGHWAY 104
P.O. Box 409099
Ione, CA 95640

August 8, 2019

Honorable Judge
Amador County Superior Court
500 Argonaut Way
Jackson, CA 95642

Honorable Judge of Amador County:

The purpose of this letter is to respond to the Amador County Civil Grand Jury's final report for Mule Creek State Prison's (MCSP) 2018-2019 inspection.

GRAND JURY'S FINDINGS:

1. The Warden is on administrative leave pending an investigation.

   MCSP agrees with the Grand Jury's finding. Warden J. Lizarraga is currently away from the institution on administrative time off as an investigation is still on going and pending.

2. Staff is generally professional and engaged.

   MCSP concurs with the Grand Jury's finding.

3. Many positive programs exist that provide benefit to the inmates.

   MCSP concurs with the Grand Jury's finding.

4. Staff can enter the secure areas of the prison without having personal effects thoroughly inspected.

   MCSP disagrees with this finding. All employees, visitors and contractors are subject to search while on institutional grounds. Quoted from the Grand Jury report, "While the grand jury was being processed through the Main Control building, several people were

being processed in and out, including employees and contract employees. Employees were often carrying coolers, backpacks, and other personal effects. According to MCSP Operating Procedure MC 156, "Allowable Employee Property," employees are permitted to bring in one hand carried item such as a cooler or backpack. However, the items being carried by employees were not "thoroughly inspected" as required by MC 156." These items are thoroughly searched at the Pedestrian Entrance not Main Control per policy. MCSP follows and enforces local and departmental policies and protocols when searching and processing anyone who is entering the secure perimeter. These inspections include but are not limited to, positively identifying the individual with photo identification, inspection of all bags for unauthorized items, walk through metal detector, and custody escorts if necessary. Enhanced inspections are also conducted on a continual basis in an effort to limit the introduction of contraband, which presents a risk to public safety and security within the institutions.

These enhanced inspections are conducted on an unannounced basis and allow for more thorough inspections of personal property, bags, and items being carried on their person. Employees who have been discovered bringing contraband into the secured area are subject to disciplinary action, which may include corrective action or adverse action.

5. Contraband remains an ongoing problem at MCSP.

   I concur with the Grand Jury's finding. MCSP staff work extremely hard to enforce and prevent any and all contraband from entering institutional grounds. MCSP believes the interdiction of contraband creates a safer environment for staff, inmates, and visitors.

6. Contamination has been found in water outside of MCSP.

   I concur with the Grand Jury's finding that contaminates have been detected in Mule Creek (the physical creek itself) both above and below the MCSP Facility. CDCR is investigating to determine what, if any, impact flow from MCSP is contributing.

7. Accreditation of MCSP by the American Correctional Association (ACA) is no longer being sought.

   I concur with the Grand Jury's finding. In 2017, California Department of Corrections and Rehabilitation (CDCR) discontinued the ACA accreditation for institutions.

8. Inspections of the medical program at MCSP by the Office of Inspector General (OIG) show need for improvement, and some improvement was realized during the last inspection conducted (Cycle 5).

I concur with the Grand Jury's finding. The recommendations provided from the OIG are a result of their July 2017 to September 2017 Cycle 5 medical inspection of MCSP. Please see attached MCSP's response to OIG's findings.

GRAND JURY'S RECOMMENDATIONS:

1. Immediately enforce existing policies regarding search of all materials entering the secure areas of MCSP.

   MCSP is currently enforcing MC 156, and was adhering to the policy on the day of the Grand Jury visit. As noted in the Grand Jury findings #4, items are thoroughly searched at the Pedestrian Entrance not Main Control per MC 156 policy.

2. Fully and transparently, cooperate with state agencies investigating the possibility of contamination originating from MCSP entering Mule Creek and the surrounding environment.

   I concur with the Grand Jury's recommendation.

   The recommendation has been implemented as outlined below.

   - Beginning in January 2018, CDCR and MCSP have been conducting a comprehensive investigation of the storm water and sanitary sewer systems in compliance with Central Valley Regional Water Quality Control Board (CVRWQCB) directives.
   - On August 17, 2018, a 534 page Storm water Collection System Investigation Report of Findings was submitted to the CVRWQCB.
   - On January 8, 2019, the CDCR participated in a public meeting with the Amador County Board of Supervisors to address the investigation.
   - The CDCR has expanded its investigation to include a closed circuit television (CCTV) inspection of all sewer and storm drain lines servicing the original facility. A technical memorandum (with sharefile video link of the camera footage) summarizing the major findings is sent to the CVRWQCB for each week of investigation.
   - On April 24, 2019, MCSP was designated a Regulated Non-Traditional Small MS4 by the State Water Resources Control Board, and added to the statewide General Permit. This designation grants the CVRWQCB a high degree of oversight and regulation over MCSP.

- MCSP continues to work closely with the CDCR's Facility Planning Construction and Management (FPCM) Division and the CVRWQCB to investigate and resolve this issue.

3. Re Engage with the ACA or another similar organization by January 1, 2020, to ensure independent oversight of MCSP operations. The protection of the citizens of Amador County is a serious responsibility, and as such, should be conducted with extensive and thorough oversite.

   Please see included Memorandum dated September 12, 2017, titled Discontinuation of American Correctional Association Accreditation.

4. Maintain the forces on improving the medical program at MCSP and strive for continued improvement in OIG medical inspections results. The goal should be "Proficient" for every inspection indicator.

   I concur with the Grand Jury's recommendation.

MCSP is committed to protecting public safety, ensuring the safety of staff and inmates, and providing proper care and supervision of all offenders under our jurisdiction while assisting their re-entry into society. I would like to thank the Grand Jury for their service and professionalism.

Should you have any questions or concerns, please contact me at (209) 274-5000.

Sincerely,

JOE A. LIZARRAGA
Warden
Mule Creek State Prison

State of California

Department of Corrections and Rehabilitation

Memorandum

Date : September 12, 2017

To : CDCR_CCHCS Extended Executive Staff

Subject: **DISCONTINUATION OF AMERICAN CORRECTIONAL ASSOCIATION ACCREDITATION FOR INSTITUTIONS**

This memorandum will serve to notify staff of the California Department of Corrections and Rehabilitation (CDCR) of the intent to discontinue American Correctional Association (ACA) accreditation, effective immediately. In its stead, CDCR will begin its own internal Security Audits through the Office of Audits and Court Compliance (OACC). Staff may archive files pertaining to ACA and maintain them according to the normal record retention schedule, as established by policy.

While ACA provided us a valued methodology for assessing the overall operation of a prison, the Security Audits will focus on critical security and Corrections 101 to enhance our operations. The purpose of the Security Audits is to assess institutional compliance with established security operations. The Security Audits will identify weaknesses, deficiencies, and areas of vulnerability that create risks to the safety and security of our institutions, including identifying any safeguards and control systems that are no longer operable, appropriate, or adequate. OACC staff, along with representatives from the Division of Adult Institutions (DAI), the Office of Correctional Safety (OCS), and the Division of Facilities Planning, Construction, and Management, will conduct on-site reviews at each institution. To complete the audits, team members will review documentation, review institution local operating procedures, interview and observe staff, observe institution practices, and inspect the institution's physical grounds.

The Security Audits program was developed in 2016 and 2017 by a workgroup consisting of OACC, DAI, and OCS staff. The Security Audits tool contains 15 components that were developed using the California Code of Regulations, Title 15; the Department Operations Manual; and various policy memoranda as the primary sources of operational standards. The new Security Audits was piloted at Deuel Vocational Institution in March 2017 and at Pleasant Valley State Prison in April 2017, with the first official audit at the California Medical Facility on July 30, 2017. We expect that all Institutions will have gone through one round of Security Audits by October 27, 2019. A tentative schedule is attached for your information and planning purposes. The Security Audits tool and final schedule will be posted soon on an OACC SharePoint site so that it may be accessed by institutional and DAI management.

One area in which ACA accreditation was tremendously helpful was the improvement and maintenance of the cleanliness of our facilities. Through the efforts of our

dedicated and hardworking staff, we have made incredible improvements demonstrating the pride in our profession and our work environment. It is my expectation that institutions maintain the high level of cleanliness acquired through accreditation.

In conclusion, I would like to thank everyone for their commitment and diligence in obtaining statewide ACA accreditation. It is not lost on me that achieving these national standards has been, without a doubt, a tremendous effort to which I applaud and am very proud of. I truly believe this decision makes fiscal sense and contributes to the wisdom of our organization by strengthening our own internal auditing functions.

If you have any questions regarding this memorandum, please contact Matt Espenshade, Deputy Director (A), OACC, at (916) 255-2906.

SCOTT KERNAN
Secretary

Attachment

cc: Matt Espenshade

Mule Creek State Prison Response

to

Office of the Inspector General 2018 Annual Report

The information that follows encompasses Mule Creek State Prison's (MCSP) responses to the recommendations provided in the Office of the Inspector General (OIG) 2018 Annual Report. The recommendations provided from the OIG are in result of their July 2017 to September 2017 Cycle 5 medical inspection of MCSP.

Exhibit 3. Medical Inspection Recommendations

1. **Description of Recommendation**: The CEO should rectify the emergency medical response review committee (EMRRC) review process because the committee failed to identify problems with MCSP's emergency response as well as with the care provided by the TTA providers and nurses. The institution needs a properly functioning EMRRC to identify and correct its various lapses in emergency care.

   MCSP Response: Effective December 2018, the EMRRC enhanced the structure of its meetings to include improvements to the review process and reporting format, data collection and validations regarding individual and systemic issues/challenges, follow up to action items, and documenting meeting minutes. The enhancements also included an initial review of all unscheduled send outs (including EMR checklist) by the frontline Supervising Registered Nurse (SRN II) by close of shift and next business day by the Chief Physician and Surgeon (CP&S), Director of Nursing (DON), and/or Chief Nurse Executive (CNE). These reviews are then reported, with action items, at EMRRC within 30 days. All identified training reported in EMRRC includes a form CDCR-844, Training Participation Sign-In Sheet.

   On or about April 2019, the Headquarters (HQ) Nursing Department began rolling out a statewide initiative and training program regarding the Emergency Response Program. These enhancements were included in MCSP's EMRRC in June 2019. These improvements began with training May 6, 2019 and will continue through October 2019. The training requirements for this initiative include 40 hours of face-to-face training in all

nursing disciplines, 8 hours for medical, mental health and dental colleagues, 8 hours academy training for officers as well as annual refresher training for all disciplines. On June 1, 2019, updated EMRRC forms were implemented (see reference 1.1 and 1.2) in efforts to better comply with OIG requirements. Lastly, the transition of EMRRC chair from nursing to CP&S became effective June 2019.

2. **Description of Recommendation**: The CEO should develop effective methods for evaluating the quality of its providers and nurses because of the poor performance of the medical staff in our review. MCSP's development of reliable and accurate methods to assess provider and nurse performance should form the basis for subsequent quality improvement in these areas.

MCSP Response: Many reliable and sustainable improvements have been made in regards to access to care through scheduling, comprehension and implementation of the Complete Care Model, and quality treatment and documentation since the last OIG Cycle 5. It was the effort of MCSP leadership and primary care teams to ensure that backlog was not a barrier to quality of care, which was identified in Cycle 5. Thus, the team implemented many measures to drastically reduce the backlog over a 90-day period. The initiatives implemented in late 2018 were successful and continue to be sustainable. MCSP does not have a backlog for the Primary Clinics, which has positively influenced patient access to care and quality of care.

In efforts to identify barriers to quality care and/or documentation of quality care, MCSP nursing department audits and provides real-time feedback and/or formal training on emergency response documentation following the emergency, monthly 7362 audits, Out to Medical Returns reviews, as well as Higher Level of Care (HLOC) Returns. Our 7362 audits have averaged 95.2% over the past twelve months. MCSP Medical Administration team routinely reviews and provides feedback the following business day on emergency response documentation, utilization management (UM), and send outs to HLOC. We have sustained compliance in the scheduling queues which are monitored daily by the Chief Medical Executive (CME) and CNE. Chronic care cases are randomly reviewed to ensure care and documentation of said care is complete and clinical appropriate. Any incomplete findings/concerns are shared with providers who are counseled, if necessary, at that time to improve their performance. HLOC send outs are routinely reviewed with providers during the morning Primary Care Provider (PCP) face-to-face huddle, which include all primary care physicians and a CP&S.

During this meeting, a clinical review can be completed as well as feedback regarding improvements in patient care, continuity, and/or on-going treatment. In efforts to assess individual clinical practices, the medical Providers have Professional Practice Evaluation Procedures, which include ongoing Professional Practice Evaluations and Focused Professional Practice Evaluations comprising of extensive case evaluations from the CP&S that are reviewed by the Regional Deputy Medical Executive (RDME) and shared with the individual provider.

To enhance transparency in quality management, and increase our patient centered focus, MCSP has seen an increase in Healthcare Incident Reports (HCIR) and has many self-imposed Root Cause Analyses (RCA) for patient safety and process improvement purposes, as well as utilize Quality Improvement Plans (QIP) for all death reviews.

Effective July 2018, MCSP implemented a Rapid Cycle Change Action Plan to enhance access to care, timeliness of services, improve quality of care and documentation of care provided, and provide additional support to primary care teams. MCSP held weekly scheduling briefings with local and regional leadership to ensure continued improved compliance, implemented daily monitoring of 7362 and HLOC data entry flag reports (see reference 2.1) to ensure appropriate order types, and met with care teams to aid in and foster the Complete Care Model within our patient care teams. MCSP has maintained compliance for all primary care Scheduling and Access to Care components for over 9 months (see reference 2.2).

Reference 2.1

PCP Routine Referrals 14 Days

Data Entry Flags - Scheduling & Access to Care	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
PCP Routine Referrals 14 Days- As Reported on Dashboard	84%	74%	77%	98%	98%	100%	99%	100%	99%	100%	98%	99%
Percent of Correctly Placed PCP Routine Referrals 14 Days	73%	83%	78%	94%	95%	96%	96%	94%	94%	94%	94%	98%
Adjusted PCP Routine Referrals 14 day Performance- Correct + Incorrect Orders	75%	69%	73%	96%	96%	99%	99%	99%	97%	99%	97%	99%

Return from HLOC 5 Days

Scheduling & Access to Care	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
Return from HLOC 5 Days - As Reported on Dashboard	87%	85%	83%	93%	99%	99%	98%	99%	97%	96%	95%	93%
Percent of Correctly Placed Orders After Return From HLOC	96%	95%	93%	95%	99%	97%	92%	96%	94%	90%	96%	97%
Percent of Patients Seen Within 5 Days After Return from HLOC – All Discharges per Hospitalization Data	81%	82%	81%	92%	95%	95%	87%	92%	87%	88%	88%	91%

Reference 2.2

SCHEDULING & ACCESS TO CARE	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	12 mo Trend
Medical Services	79%	78%	76%	89%	92%	91%	91%	90%	88%	90%	83%	83%	
RN FTF Triage 1 Day	85%	83%	86%	95%	[illegible]	97%	97%	93%	98%	97%	97%	96%	
PCP Urgent Referrals 1 Day	96%	89%	82%	95%	100%	[illegible]	96%	97%	92%	96%	97%	93%	
PCP Routine Referrals 14 Days	84%	74%	77%	98%	93%	100%	99%	100%	91%	100%	[illegible]	99%	
Episodic Care Follow-Up as Ordered	-	-	-	-	-	-	-	-	-	-	99%	99%	
Chronic Care as Ordered	[illegible]	[illegible]	79%	100%	99%	99%	[illegible]	99%	99%	[illegible]	100%	100%	

As of the April 2019 Dashboard, MCSP had a Primary Care Provider (PCP) Backlog of 2.2 per 1000 patients (9 appointments), a Registered Nurse (RN) rate of 0.2 (1 appointment), and a Licensed Vocational Nurse (LVN) rate of 0.2 (1 appointment). MCSP is currently ranking well below the statewide averages for these measures (see reference 2.3). In focusing on all aspects of quality improvement, MCSP has maintained an almost all green (compliant) dashboard for the past twelve months for Electronic Health Record System (EHRS) Timely Documentation (see reference 2.4).

Reference 2.3

Scheduling & Access to Care	SW	MCSP
PCP Backlog	14.2	2.2
RN Backlog	5.3	0.2
LVN Backlog	5.0	0.2

Reference 2.4

AVAILABILITY OF HEALTH INFORMATION	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
EHRS Timely Documentation	94%	94%	94%	94%	93%	93%	94%	92%	92%	92%	92%	95%
PCP Documentation	99%	98%	97%	98%	97%	93%	[illegible]	98%	99%	99%	99%	99%
PC RN Documentation	[illegible]	95%	91%	91%	90%	89%	[illegible]	81%	[illegible]	81%	[illegible]	97%
LVN Documentation	90%	91%	92%	95%	92%	91%	88%	91%	89%	92%	81%	86%

3. **Description of Recommendation**: The CEO should identify and correct several of its specialty services processes because of the institution's problems with providing specialty appointments for patients with urgent referrals, for newly arrived patients with pending referrals, or for patients who need specialty follow-up appointments.

MCSP Response: The Specialty Services department has been a focus for MCSP, which has included a Greenbelt project and the development of the Specialties Executive Oversight Team. The dashboard for Urgent, High Priority Specialty 14 Day, appointments has been improving and more comparable with the statewide average, which is currently at 68%, in the red for April (See Reference 3.1). Effective February 2019, MCSP and San Joaquin General Hospital (SJGH) initiated monthly conference calls to help address issues and concerns that both sides have. These calls have greatly improved communication and provided an open forum for necessary topics to be discussed. We continue to work with HQ and our contract teams to increase the availability of Specialty Services. In doing so, we have been better able to determine the appropriate needs for each Specialty Service. In result, we have brought additional services onsite as well as restructured Specialty clinic days and times.

Reference 3.1

SCHEDULING & ACCESS TO CARE	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
High Priority Specialty 14 Days	34%	65%	38%	52%	67%	57%	59%	51%	66%	68%	**79%**	**75%**

Our Receiving and Release (R&R) department has been screening new arrivals looking for approved Physician Request for Services (RFS) as well as our UM Nurses in order to catch all Specialty Services pending during transport from other institutions as well as HLOC returns. The updated Scheduling and Access policy was implemented statewide in April 2019, which does not require an automatic Specialty follow-up appointment, with the exception of High Priority visits. This change positively impacted our clinics to ensure our providers are seeing patients based on need and medical necessity upon Specialty return. All other Specialty follow-ups are determined when the provider reviews the specialist notes.

4. **Description of Recommendation**: The CEO should isolate and fix those laboratory processes that resulted in the high, recurring rate of noncompletion of laboratory tests we identified in this cycle.

MCSP Response: During Cycle 5, the OIG clinicians expressed concern regarding the fact that there had been no Laboratory Supervisor until one was hired in May of 2017, near the end of the OIG case review period. The OIG clinicians believed that the absence of supervision in the laboratory department explained why the institution's performance in this indicator regressed in Cycle 5. As of February 2019, a Senior Clinical Technologist was hired as the new Lab Supervisor. The implementation of

Cerner in October 2017, along with the consistent leadership and oversight in the lab, has continued to enhance compliance in all areas of the drawing station's diagnostic activities.

Focusing efforts on diagnostic processes, in March 2019, MCSP implemented an enhanced refusal procedure to address patients who refuse to report in person for scheduled lab draws. In accordance with the new procedure, when a patient refuses to appear in person for his lab draw, the Lab Assistant alert the clinic Licensed Healthcare Professional who go cell-side to see the patient in person. While cell-side, the staff will encourage the patient to have their labs drawn, explain the benefits of doing so, as well as the clinical risks of refusing. Refusal data is being collected and monitored to measure the effectiveness of this recently implemented change. Additional improvements have been made to the Fecal Occult Blood Testing process (see reference 4.1). Nursing staff review the Registries, propose orders for the required tests and the Lab ducats the patient. If the patient refuses the procedure, the information is entered into the Health Maintenance section of Cerner.

In review of the dashboard data, the Laboratory Services as Ordered measure has consistently remained green (compliant) for the past twelve months (see reference 4.2).

Reference 4.1

POPULATION HEALTH MANAGEMENT	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
Colon Cancer Screening	79%	79%	77%	80%	83%	84%	85%	84%	84%	85%	84%	[illegible]

Reference 4.2

SCHEDULING & ACCESS TO CARE	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
Laboratory Services as Ordered	96%	95%	[illegible]	97%	97%	97%	96%	97%	97%	[illegible]	98%	97%

5. **Description of Recommendation**: The CEO should analyze and adjust many of its pharmacy and nursing processes to correct the problems we found with medication administration and medication continuity.

MCSP Response: MCSP has worked to develop better compliance in medication management and has identified the largest barrier to improvement initiatives as patients failing to report for their medications as well as refusals of medication. With the continued efforts of the clinical and healthcare access team members, there has been some improvement in the Medication Administration Process Improvement Plan (MAPIP) scores, most notably the Keep-On-Person (KOP) indicator (see reference

5.1). In August 2018, MCSP implemented a KOP ducating process to assist in increasing compliance. If the patient fails to pick up their KOPs within the first two days, the patient receives a priority ducat. This is in addition to posting the KOP list in the housing units and at the medication windows.

Reference 5.1

MEDICATION MANAGEMENT	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
By Administration Type												
KOP	79%	84%	82%	85%	86%	88%	87%	87%	85%	88%	90%	88%

MCSP will be rolling out the Correctional Clinic model utilizing stock medications, which should assist with the availability of medications to include the reduction of transporting medications for intra-facility transfers. The Correctional Clinic model has an estimated rollout date of July 2019.

In efforts to further improve medication administration and continuity, pharmacy staff review the daily transaction report for all medication that is to be used for "X" number of days (i.e. antibiotics for 3 days, prednisone taper for 7 days). This process accounts for all medication used and ensures the remaining is an accurate account for all current orders.

6. **Description of Recommendation**: The CEO should create and institution-wide anticoagulation management system to help track, monitor, and intervene for patients taking anticoagulation medication because the individual providers were unable to do so independently.

MCSP Response: The MCSP Warfarin strike team was activated June 1, 2018. Team members involved in the process were the Pharmacist in Charge (PIC), CP&S, Lab Assistant/Lab Supervisor and Public Health Registered Nurse (PHN). The goal for this strike team was to move the Dashboard measure from yellow to green, with a target goal of 90%, or better, by December of 2018.

Meetings held from July to December 2018 established criteria for warfarin alternate therapy, when clinically indicated. These meetings were also used to review current patients on warfarin as well as educating the primary care teams, specifically the providers, to the criteria for warfarin and/or alternative treatments. The CP&S played an instrumental role in reviewing the patient charts, working with Pharmacy and yard providers, to ensure that the appropriate application of the criterion was met when

ordering warfarin and/or transitioning to alternatives. Average number of patients on warfarin from July to December 2018 was approximately 62.

The primary care providers, with the assistance from the strike team, was able to successfully transition approximately 17 patients to one of the following alternatives: Eliquis, Pradaxa, or Xarelto. Two of the 17 patients were transitioned back to warfarin due to medication intolerance/side effects. As of December 2018, the warfarin dashboard measure for therapeutic anticoagulation was at 85% (see reference 6.1).

Reference 6.1

POPULATION HEALTH MANAGEMENT	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
Therapeutic Anticoagulation	75%	75%	77%	78%	76%	81%	88%	85%	88%	88%	77%	87%

Further attention was given to increase warfarin patient education. The Public Health Nurse (PHN) worked with the MCSP communication coordinator to provide weekly television media to patients (November and December 2018). This was achieved via airing the warfarin education guide on the patient television. The PHN was also responsible for coordinating with the yard RN to complete patient education with patients that were out of compliance.

The strike team strives to improve care coordination within the care teams. To ensure further compliance the following enhancements have recently been implemented.

a. The SRNIIs work with providers and nurses during population management and report updates/changes to the PIC by the 20th of each month.
b. The yard Office Technician (OT) print the out-of-range International Normalized Ratio (INR) labs and provide to each yard care team to discuss during morning report huddle.
c. The Lab Supervisor provides a weekly list of patients that are out of compliance on the warfarin registry *to the SRNII for review in the huddle.*
d. The Lab Assistants ensure that patients on warfarin have active labs orders for PT/INR's and are to report to the provider any patients that are out of compliance or non-adherent with lab draws.

**If a patient's warfarin is discontinued, it takes 30 days for their name and INR levels to drop off the registry. The PIC validated this delay on 6 patients whose orders were discontinued but still showed on the registry.*

Warfarin's narrow therapeutic range makes this a difficult measure to sustain, but we are ensuring every effort is made to curtail these challenges.