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COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

MICHELLE M. PARKER
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

JEREMY C. TOTH
SECOND ASSISTANT COUNTY ATTORNEY

May 22, 2015

Honorable Members of the Legislature
County of Erie
92 Franklin Street, 4th floor
Buffalo, NY 14202

Re: COMM. 10E-27 (2015)
Department of Health – Correctional Health – new positions
Quality Improvement Nurse & Assistant Director of Nursing

Dear Honorable Members:

This is sent to you in support of the Legislative Resolution associated with Correctional Health's request for two additional positions: 1) Quality Improvement Nurse and 2) Assistant Director of Nursing.

As you know, the operations of the Division of Correctional Health are currently under the oversight of a Technical Compliance Consultant, Ronald M. Shansky, M.D. This is pursuant to the terms of an August 2011 Stipulated Order of Dismissal arising from a 2009 lawsuit brought against the County by the U.S. Department of Justice.

The terms of the Stipulated Order of Dismissal provide that Dr. Shansky will evaluate the status of compliance for each provision of the Stipulated Order. Pursuant to that evaluation, Dr. Shansky has recommended that the County create the position of Quality Improvement Nurse and of Assistant Director of Nursing, in order for the County to reach substantial compliance with the provisions of the Stipulated Order. *See* May 2014 Report, p. 10; November 2014 Report, pp. 9, 10, 12.

In order for the County of Erie to comply with the recommendation of Dr. Shansky, it is necessary that this Honorable Body approve the creation of the positions of Quality Improvement Nurse and of Assistant Director of Nursing.

Should this Honorable Body require further information, please contact me. Thank you for your attention to this matter.

Dr. Shansky's Hiring Recommendation
May 22, 2015
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Very truly yours,

MICHAEL A. SIRAGUSA
Erie County Attorney

By: 
Michelle M. Parker
First Assistant County Attorney
Michelle.Parker@erie.gov
(716)858-2209

MMP/dld

cc: Hon. Mark Poloncarz
Hon. Timothy Howard
Michael A. Siragusa, County Attorney
Gale R. Burstein, MD, MPH, FAAP, Commissioner of Health
John Greenan, Chief of Administration
Christa Cutrona, RN, MSN, Director of Correctional Health

Seventh Monitoring Report

US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the Seventh Monitoring visit, which took place from November 17-21, 2014. This particular review was affected by a major snowstorm which fell heavily on southern Buffalo and prevented the team from accessing the Erie County Correctional Facility. Additionally, the storm created such disruptions to traffic flow that both correctional officers and health care staff found it difficult if not impossible to get to the facilities. Downtown Buffalo, which is where the Erie County Holding Center is located, did not have nearly as much snow, probably an accumulation of about 6-8 inches during the week. We were able to review all of the elements of the program at the Holding Center (except for medication administration) despite not being able to go to the Correctional Facility. The County staff were remarkably accommodating in assisting us through the process despite the multiple emergencies to which they had to respond. We are greatly appreciative of the efforts made by the Erie County custody and health care staff.

The major area affected by the weather in terms of my review was medication administration, which because of staff shortages due to the weather resulted in only emergency and critical medications being administered. The section related to medication administration will be described at that time.

B. Medical Care

1. Policies and Procedures

Compliance Status: Provisionally substantial compliance pending receipt and acceptance of modified policies.

Findings

The Director of Health Care Services informed me that there have been revisions to some of the policies and procedures within the past six months. These revisions are to be signed by the Commissioner of Health and the custody leadership. I was not able to be provided access to these changed policies and procedures; however, I will assess the compliance status as provisionally substantial compliance pending receipt of the modified policies and procedures.

The Chief Medical Officer or Medical Director should also participate in the promulgation and/or review of policies. Because this position has remained vacant there is no real opportunity for such participation. However, we will review the changes to the existing policies when we receive them.

Recommendations

1. Please forward the modified policies and procedures to the medical monitor when they are available.
2. Begin to implement per our discussion nursing professional performance enhancement reviews to expand on what you have already initiated.

2. Medical Autonomy

Compliance Status: Unable to assess.

Findings

Although the assessment was substantial compliance at our last visit despite the fact that the CMO position had been vacant for six months, I was modifying the method I used to make the assessment. Ordinarily I utilize discussions with both custody leadership and the CMO as well as the Nursing Director and any record reviews that raise questions in order to assess medical autonomy. Since medical autonomy had been in substantial compliance based on a very constructive working relationship between the clinical leadership and the custody leadership, I had reason to believe that this principle would not be violated. However, in the face of vacant clinical leadership for 12 months I am not able to fully assess medical autonomy. Custody cannot develop a relationship when there is a vacancy in the key clinical leadership position. I am not assessing partial compliance because I have no data that supports moving the compliance status backward. I have been apprised of the recruitment efforts made by the Department of Health over the last year. Those efforts have been significant. There may be a variety of reasons why the position has remained vacant for 12 months. The one apparent reason is that the compensation package has not been perceived as acceptable to the selected candidates. This suggests to the monitor that the Department of Health must use more creative strategies than sticking with the civil service system or a fee for service dollar figure that equals salary plus benefits. In this monitor's experience, correctional health programs can become fragile and deteriorate rapidly in the absence of dependable, constructive clinical leadership. This problem must be successfully addressed soon.

Recommendations

1. Fill the Medical Director position.

3. Privacy

Compliance Status: Substantial compliance.

Findings

Although we did not tour the areas where assessments are performed, we were assured that all assessments at both facilities are performed in an appropriate clinical space, both in the housing

units and in the clinic areas. I have also been assured that this program does not perform cell-side assessments.

Recommendations

1. Continue to emphasize with staff the obligation to insure that all assessments are performed in a manner that affords appropriate privacy.

4. Training of Custody Staff

This area has been in compliance for 18 months.

5. Management of Health Records

Compliance Status: Partial Compliance.

Findings

As a result of bureaucratic delays, the implementation of the electronic record has yet to begin. We do know that a contract has been signed and the vendor has been onsite and also remotely working with the correctional health staff in preparation for the implementation. These are encouraging signs. We also visited the record area and found the filing in both locations not excessively backlogged. During our record review, we did identify records, especially for people with multiple problems and incarcerated longer periods of time, to be somewhat disorganized, both with regard to the sections in which documents were filed and within a section with regard to correct chronologic order. We know these problems will be eliminated by the introduction of the electronic record. However, there remains a current obligation to maintain the records in such a way that they facilitate use by clinicians and thus facilitate better patient outcomes.

Recommendations

1. Have medical records staff focus on insuring appropriate record management, including filing, in those records which are thicker.
2. Continue the groundwork being laid with the selected vendor so that implementation goes as smoothly as possible.

6. Medication Administration

Compliance Status: Unable to assess.

Findings

As a result of the massive snowstorm resulting in up to eight feet of snow in some parts of south Buffalo, it became impossible to insure that both custody staff numbers and health care staff numbers were adequate for the medication administration. In light of this, critical medications were identified and these were administered, as far as we understand, on each and every day. However, without adequate staffing it became impossible to meet with routine medication

administration demand. Additionally, we discussed the issue of both the nursing and the health care staff response to repeated missed or refused medications. The policy requires the nurses to notify the clinicians regarding three doses refused or missed in a row. This notification should include scheduling the patient with the clinician. At that visit, the clinician is obligated to query the patient as to why this is happening and based on the response, either develop a plan that is likely to facilitate adherence or decide that this particular medication is no longer indicated. In our last review, when clinicians were informed of the sequence of refusals or missed meds, nothing was changed. An internal study was performed by the Office of Health Services and a separate study was performed by forensic mental health. Both studies showed some improvement but the problem had not yet been resolved.

Recommendations

1. Continue working with both nursing staff and clinician staff about their responsibility to respond to a sequence of missed or refused medications.
2. The quality improvement program should select MARs that reflect the work of a variety of nurses, selecting MARs for patients who are on multiple medications multiple times per day. In reviewing these medication administration records a calculation should be performed of the error rate, meaning the rate of blank spaces versus the total number of expected doses administered. This error rate should not only be used to improve performance but it should also be reported in the quality improvement minutes at least quarterly.

7. Access to Care

Compliance Status: Partial compliance.

Findings

We have good news in that in our review of records of patients who have submitted sick call requests, they were almost always seen within one day. However, the infrastructure to monitor timeliness has still not been developed because the logbook that would allow visual tracking from fields that list date of receipt versus date of face-to-face assessment has not yet been set up. As indicated previously, this allows very rapid review of a substantial amount of data without a great deal of effort. We strongly encourage setting up this methodology. Additionally, we found the professional performance by the nurses inconsistent. Some performed well and others performed not as well. The problems we identified included inadequate history taking, inadequate assessment and inadequate plan. The types of inadequate history included not querying regarding all of the symptoms listed on the sick call slip but also not querying sufficiently with regard to specific types of symptoms. The problem of not reviewing with the patient the specific symptoms listed on the request stems from an urgent care type of approach in which the patient is seen without any records. Sick call is not an urgent care encounter because

there is a written request from at least one day earlier and that request has to be addressed. This should be reviewed with all nurses who perform sick call.

Recommendations

1. Set up a log book that allows visual tracking of symptom complaints for date of receipt, presenting complaint, date of nurse assessment as well as disposition (referral to ALP or not).
2. The QI program should present data from these logbooks with regard to average timeframe between receipt of request and nurse face-to-face assessment.
3. The QI program should monitor the average timeframe from nurse referral to advanced level clinician with a timeframe target of no more than five business days for the referral to be accomplished.

8. Emergency Care

Compliance Status: Substantial compliance.

Findings

We again reviewed seven records of patients seen urgently and all except one were sent offsite on an emergency basis. Overall, these patients were assessed timely prior to send out. An advanced level provider was notified and recommended the patient be sent out. When the patient returned, the appropriate offsite documents were available and the patients were seen by a nurse and subsequently by an advanced level clinician within a few days after return. In most of these follow-up visits there was documentation of a discussion regarding the findings and plan. However, we continued to find a record in which there was no emergency room report, another record in which there was a missing nursing note upon return and one or two records in which either the follow-up visit did not occur or what should have been a follow-up visit that included a discussion of the findings and plan lacked that discussion. Because we did not find a pattern of any of these deficiencies, we continue to rate the service as being in substantial compliance. We continue to believe that the quality improvement program could identify explanations for why these things are happening and from that analysis could lead to improvement strategies which would eliminate the problems.

Recommendations

1. The QI program should be monitoring emergency offsite visits and insuring that the offsite service reports are retrieved timely, reviewed by the clinician and then discussed with the patient at a visit shortly after the emergency room trip.

9. Follow-Up Care

Compliance Status: Partial compliance.

Findings

We reviewed eight records of scheduled offsite services, including a mixture of both consultations with specialists as well as procedures. We continued to find a mixture of quite common deficiencies; in fact, a majority of the eight records contained one or more of the following deficiencies. Those deficiencies included the absence on return of a note by a nurse, the absence of a follow-up discussion between an advanced level provider and the patient and in a few instances, the absence of the offsite service report. This area continues to be a problem and merits special attention by the QI program. We did not review records from the correctional facility which, in our previous visit, contained even a higher percentage of deficient records. We are concerned that not only has this service not progressed but in fact it may have taken a step backward.

Recommendations

1. The quality improvement program should monitor at each site a sample of patients sent offsite for scheduled offsite services. The monitoring should include the timeliness of the appointment, the presence of the offsite service report upon return and the follow-up visit with an advanced level clinician in which they document a discussion of the findings and plan with the patient. When there is a breakdown in any of these steps, the QI program should assess the contributing factors and develop improvement strategies to mitigate the occurrence of these factors.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

It is not surprising with a vacant Medical Director position for the last 12 months that we are not seeing substantial progress in the area of chronic disease management. This is an area that requires the Medical Director to review and work with the advanced level clinicians in order that their performance be improved. During this visit we looked at a variety of diseases, focusing as we had before on diabetes as well as HIV, asthma and seizure disorder. We also reviewed a record of a patient receiving anticoagulation. Of the 11 records we reviewed, four were of patients with diabetes. Among the records reviewed were patients with both type 1 and type 2 diabetes; however, it was common for the problem list and the notes not to reflect the type of diabetes that the clinician was addressing. Given the difference in physiology between the two types of diabetes, not appreciating this difference is likely to lead to care problems. We found that in the initial chronic disease history there was no effort to identify the age of onset of the disease, which is very important in determining whether the patient has type 1 or type 2 diabetes. We also found that patients with asthma did not have a peak flow measurement whether they were being assessed during an acute attack or whether they were being assessed when they were stable during a chronic clinic visit. In fact, one patient who by history was having 2-3 nighttime

awakenings per week and was on inhaled steroids did not have his degree of control assessed nor was the patient given a follow-up visit sooner than three months. With regard to HIV disease, it is not clear why at the first chronic clinic visit, although a CD4 count was ordered, no viral load was obtained. When the patient was sent to the offsite clinic, the clinic recommended to have the patient return with a viral load. Also, it was not clear that the primary care chronic clinic clinician was querying the patient regarding side effects of the treatment regimen. On the positive side, when we reviewed significantly diminished serum Dilantin levels, each patient was seen by a clinician after the lab test was reviewed and discussions regarding adherence and/or changing doses were documented. It is critical to fill the Medical Director position so that the advanced level clinicians can improve their clinical performance. In the absence of feedback and discussion, it is guaranteed that performance will not improve.

Recommendations

1. Have the lab send a list of individuals who have had a hemoglobin A1c within the prior month along with the name of the patient, the specific results and the date that the lab test was performed.
2. Have the consulting Medical Director review the records of patients whose hemoglobin A1cs are above 9.0, indicating poor control.
3. Reinforce with the nursing staff and the clinicians the importance of assessing asthma by use of the peak flow meter.

11. Dental Care

Compliance Status: Provisional substantial compliance.

Findings

We learned that the x-ray equipment at the correctional facility is broken and needs to be repaired. As a result, certain procedures such as extractions cannot be performed, since it is a standard of practice to have an x-ray prior to any extraction. We discussed with the dentist and the Director of Correctional Health the possibility of utilizing the x-ray unit at the holding center on a weekend day and bringing 10 patients a week from the correctional facility to the holding center to obtain these x-rays. Custody indicated they would be fully supportive of this strategy to be used on an interim basis until the x-ray equipment at the correctional facility is in fact repaired. The provisional substantial compliance is based on implementing this strategy and in addition, repairing the equipment so that it is ultimately functional.

Recommendations

1. Get the x-ray equipment repaired.
2. Implement a system to have x-rays performed on correctional facility patients at the holding center on weekends until those services are no longer needed because the x-ray equipment at the correctional facility has been repaired.

12. Care for Pregnant Prisoners

Compliance Status: Substantial compliance.

Findings

We reviewed the two records of pregnant patients currently housed at the holding center. In both cases, the pregnancy was identified during intake, the patient was seen by an advanced level provider onsite and then followed up at Women and Children's Hospital in the prenatal clinic. In addition, in both cases the relevant documents from the prenatal clinic were available and reviewed by the onsite clinicians. One patient, during the course of her stay, delivered a baby and the records reflect both the prenatal and post-delivery care.

Recommendations

1. The quality improvement program should continue to track the timeliness of initial advanced level provider assessment after determination of pregnancy as well as timeliness of offsite service obstetric visits from time of diagnosis.

13. Dietary Allowances and Food Service

Compliance Status: Substantial compliance.

Findings

We toured the kitchen at the holding center and interviewed the Director of Food Services. We were unable to go to the correctional facility and also unable to interview the dietitian. We hope to interview the dietitian during our next visit. In looking at the special diets currently assigned, we queried the Food Service Director as to which items from the standard menu would have to be substituted for, as an example, a diet for diabetics. He appeared knowledgeable and answered our questions both timely and correctly. Although we would have liked to have discussed this with the dietitian, we will await that interaction for our next visit. The Director of Food Services appeared knowledgeable enough to appropriately make the special diet substitutions.

Recommendation None.

14. Health Screening of Food Service Workers

This area is in sustained compliance.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

We were informed by the Director of Correctional Services that there has been approval of a nurse to be hired with responsibilities to both direct the quality improvement program and

function as the infection control nurse. We are encouraged by this since there are several functions which need to be better organized. The infection control nurse should collect data presented at a quarterly quality improvement meeting with regard to both the TB surveillance program as well as the skin infection program. In addition, there is a requirement to summarize the data on reportable cases also. Finally, the areas in which assessments are performed need to be monitored at least monthly and assurance be provided that effective sanitary procedures have been implemented. We look forward to the hiring of this nurse, both for the infection control program and for the quality improvement program.

Recommendations

1. Hire the person who will be responsible for both infection control and quality improvement leadership.
2. Establish a system to monitor both culture proven and presumptively treated MRSA cases on a monthly basis.
3. Report both categories of MRSA cases at the QI meeting on a quarterly basis.

16. Sexual Abuse

Compliance Status: Partial compliance.

Findings

We were provided with the sexual abuse allegation log and attempted to identify cases which were sent offsite and for which a SANE exam was provided. It was extremely difficult to read the log and it would have helped if the log contained a field for "sent to the hospital" and a second field for "SANE exam completed." The sexual abuse coordinator indicated he would modify the log in the future. We reviewed two records of patients sent offsite for which a SANE exam was performed. It is not clear whether others may have been performed but we were unable to discern them. The sexual abuse coordinator believes that is the case. Of the two cases we reviewed, it was clear that a SANE exam had been performed; what was not clear was any direction given to both the medical and mental health staff with regard to follow up. The PREA standards specifically require follow up based on the nature of the assault and gender of the victim with regard to sexually transmitted disease treatment as well as pregnancy counseling. When you receive a report from a hospital that only indicates "exam performed," you have no guidance as to what their recommendations are. In addition, we had no documentation that rape crisis counseling was provided and whether more mental health services were recommended. Because of the absence of guidance from the hospital this area remains in partial compliance. We discussed with the Director of Correctional Health Services his need along with relevant custody staff to meet with the leadership at the hospital so that the communication back to the holding center does provide the necessary guidance.

Recommendations

1. Modify the sexual abuse assault log to add fields for both sent out to hospital and SANE exam done.
2. Meet with the leadership of the hospital and convey to them the need for follow-up guidance to be provided as a result of the SANE exam and/or the rape crisis counseling. This guidance should be part of the paperwork that returns to the facility.

17. Quality Management

Compliance Status: Partial compliance.

Findings

Although there is no Quality Improvement Coordinator, we have been assured by the Director of Correctional Health Services that a position has been approved and he intends to hire after the first of the year. Not surprisingly, the quality improvement program is substantially underdeveloped. There have been studies which we have reviewed with regard to medication errors, medical incidents, completeness of nursing documentation, CIWA assessment performance and missed medications. The studies that I reviewed were incomplete in that they contain data but no analysis against a standard, no determination of whether the performance was satisfactory and if the performance was not satisfactory, no development of an improvement strategy. These are all the requirements of an adequate quality improvement program. I will be happy to spend time with the Director of Correctional Health Services, the Director of Nursing and the new Quality Improvement Coordinator indicating my expectations with regard to the requirements of the quality improvement program as it addresses the areas in this Memorandum of Agreement. I look forward to working with the leadership team and expect that progress will be made soon.

Recommendations

1. Fill the Quality Improvement Coordinator position and the Assistant Director of Nursing position as soon as possible.
2. Work with the IT consultant regarding the ability to track critical elements through the electronic medical record by recustomizing encounter forms where indicated.
3. Perform the studies referred to under the recommendation section consistent with the recommendations we have made. If necessary, please feel free to contact the medical monitor.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Non-compliance.

Findings

The 12 month vacuum in this position creates potential insecurity for the advanced level clinicians as well as lack of oversight of significant clinical decision making. This position needs

to be filled as soon as possible with the appropriately credentialed clinician. The County must become creative in designing an attractive package for any applicants.

Recommendations

III. Protection from Harm

E. Training of Officers with Regard to Sexual Abuse and Policy on Handling Sexual Abuse

Compliance Status: Sustained substantial compliance.

Findings

Both the policy and the training are consistent with the continuation of substantial compliance.

Recommendation None.

I. Training of Medical and Mental Health Staff

Compliance Status: Substantial compliance.

Findings

Both the medical and mental health staff have completed their training with regard to the handling of sexual abuse. The percent trained is well above 90%.

Recommendation None.

J. Suicide Prevention Program

e. Privacy

Compliance Status: Sustained substantial compliance.

Findings

See number 3 under Medical Care section.

Recommendation None.

f. Assessment of Inmates in Detoxification

Compliance Status: Substantial compliance.

Findings

The detoxification unit continues to function as a well-designed program.

Recommendation

1. The QI program should continue to monitor the compliance of the nursing staff in performing the CIWA assessments.

D. Training of Officer Staff with Regard to Suicide Prevention Training

Compliance Status: Sustained substantial compliance.

Findings

This area remains in substantial compliance and has achieved sustained compliance.

3. Detoxification Training Program

Compliance Status: Sustained substantial compliance.

Findings

All of the required medical staff have had this training.

Recommendation None.

Summary of Findings

This monitoring visit was clearly affected by the challenging weather conditions. We were impressed with the ability of the custody staff and their leadership team to respond to the challenges with which they were presented. We appreciated the accommodations in their schedules in order to facilitate our review. Although this monitor was unable to review the program at the correctional facility and also unable to review medication administration under normal conditions, nonetheless the rest of our monitoring visit was completed within the expected timeline. We cannot emphasize enough the need to fill the Medical Director position and use some flexibility and/or creativity in developing a compensation package that is satisfactory. We also want to emphasize the importance of filling the Infection Control/Quality Improvement Coordinator position as well as the Assistant Director of Nursing. Although only two areas moved from partial compliance to substantial compliance, we were encouraged that in the absence of clinical leadership, greater deterioration had not occurred. We look forward to working with the team including the new leadership when these key positions are filled and also witnessing the implemented electronic record system.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

RS/kh

Sixth Monitoring Report

US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the Sixth Monitoring visit, which took place from May 13-17, 2014.

B. Medical Care

1. Policies and Procedures

Compliance Status: Substantial compliance drafting of policies; substantial compliance implementation of policies.

Findings

Under the leadership of the Director of Health Care Services and the Director of Nursing, policies remain in compliance and in most areas, implementation improved. There is no question that the absence of a Medical Director has had a negative impact on the program. This is particularly true with regard to professional performance improvement of the advanced level clinicians. We were encouraged to hear that a successor Medical Director has been identified and is able to begin employment in that role in early September 2014. We also learned that this candidate is interested in working on a fee-for-service basis before then by involving himself in the professional performance improvement program with the advanced level clinicians.

Recommendations

1. Please forward the curriculum vitae of the newly selected Medical Director to the medical monitor.
2. Develop a format for systematic and consistent review of professional performance of the advanced level clinicians by the Medical Director. The medical monitor would be happy to assist in the development of this performance review.

2. Medical Autonomy

Compliance Status: Substantial compliance.

Findings

Although there has been a vacuum in the clinical leadership of the medical program, the medical monitor has developed a degree of confidence in the professionalism of the custody leadership such that it is my belief that custody leadership will not exploit this vacuum by intervening in necessary medical decisions. It will be up to the new Medical Director to again establish credibility with custody leadership and it is our belief that this certainly is achievable.

Recommendation: None.

3. Privacy

Compliance Status: Substantial compliance.

Findings

Besides the improved privacy provided by the new intake space, we learned that at the Alden Erie County Correctional Facility the room in the hallway will not be utilized. Rather, an additional exam room has been created in the clinic area. We are also aware that in the pod housing units there is an appropriately equipped examination room which affords the required privacy. Although there is no such room in the linear designed housing units, we are aware that patients are brought instead to the main clinic area where such privacy can be afforded.

Recommendation

1. Continue to provide appropriate privacy for any and all clinical assessments. This precludes any assessments being conducted cell-side.

4. Training of Custody Staff

This area has been in compliance for 18 months.

5. Management of Health Records

Compliance Status: Partial Compliance.

Findings

Although the backlog in inactive records has been eliminated, the effort to integrate all medical and mental health documents into the same record has resulted in increased filing needed to be performed for the active records. At the time of this visit, the loose filing area contained between seven and eight inches of unfiled documents that extended as far back as mid-April. These documents were mostly mental health initiated documents. It is expected that the electronic health record will go live as early as September of this year and certainly before our next visit in November. This should eliminate any of the active record filing as well as inactive record filing within six months of the implementation of the electronic record. The medical monitor is familiar with the particular software chosen and has experience with it, finding it quite user friendly. Another positive aspect of this software is that it is easily customizable with regard to the data entry screens which can be customized by local staff or a consultant to the program. We look forward to this section coming into substantial compliance.

Recommendation

1. Work closely with the IT integration vendor in order to design encounter forms that allow tracking and reporting on important data fields and also to insure that the transition from paper to an electronic record goes as smoothly as possible.

6. Medication Administration

Compliance Status: Substantial compliance.

Findings

Once again, we observed both morning and evening medication administration in both the linear housing units and in the pods. We were pleased to find that the nurses continue to perform both appropriately and professionally. We found that there was helpful participation by the correctional officers. We also found that there had been retraining of nurses such that there was consistency with regard to how they documented inmate refusals of specific medications. We also learned that there has been retraining with regard to the manner of documentation when as needed medications are felt by the patient not to be needed. Finally, we were particularly pleased with the nursing staff compliance with the policy requirement that when a patient refuses a medication for three consecutive medication passes they are referred to the ordering clinician. We observed several medication administration records where there were consecutive refusals and the patients had been referred to the clinicians. This was especially common with regard to the forensic clinicians. We were quite disappointed, however, with the response of the forensic clinicians who neither documented counseling nor made any effort to modify or revise the existing regimen. The purpose of the referral is for any clinician to explain the risks and/or benefits and to work out with the patient a regimen that is much less likely to be refused. There was no documentation that we saw that achieved these goals. We also believe that blank spaces that occur on medication administration records where the medicine is ordered at least daily should be treated as medication errors.

Recommendation

1. The quality improvement program should select MARs that reflect the work of a variety of nurses, especially for patients who are on multiple medications, multiple times per day. In reviewing these medication administration records, a calculation should be performed of the error rate, meaning the rate of blank spaces versus the total number of expected doses administered. This error rate should not only be used to improve performance, but it also should be reported in the quality improvement minutes at least quarterly.

7. Access to Care

Compliance Status: Partial compliance.

Findings

We were pleased to observe that the logging of medical sick call requests is occurring and these requests have been separated into symptom describing requests and other so-called administrative or informational requests. However, the manner in which they were recorded does not easily allow for a simple observation of the timeframe between request received and face-to-face assessment having occurred. We believe it will be more useful to have a logbook that lists patient identifiers, date received, nature of the complaint, date of assessment and disposition. This would allow to visually determine the average timeframe in which these assessments occur simply by glancing at the two columns, date received and date of assessment,. Finally, with regard to the disposition, we attempted to do a study looking at the records of patients in which the disposition described referral to an advanced level provider. The first five such records we pulled contained zero notes by an advanced level clinician. We learned that a policy had been implemented in which, when the nurses refer the patients to the advanced level clinicians, these advanced level clinicians had a choice of reviewing the record alone or also seeing the patient. In none of the records we reviewed was the patient seen face-to-face for an assessment by an advanced level clinician. Therefore, we are strongly recommending that the policy with regard to referral be changed. The discretion by an advanced level clinician of only reviewing the record should be eliminated. We have never heard of an instance where a patient learned anything when their record had been reviewed by any clinician. The choices the nurses should have is to either discuss the case with the clinician at the time the patient is there or refer the patient to the clinician for a mandatory face-to-face assessment by the clinician. We also discussed with the Director of Health Services that it is very important that no clinicians are allowed to conserve personal energy by manipulating the list of patients they are to see in such a way that their workload is reduced.

Recommendations

1. Set up a logbook that allows visual tracking of symptom complaints for time of receipt, presenting complaint, time of nurse assessment as well as disposition.
2. The QI program should present data from these logbooks with regard to average timeframe between receipt and nurse assessment.
3. Eliminate the advanced level provider review and make all referrals to an advanced level provider mandatory, face-to-face assessments where they can help understand the patient's problems and educate their patient.
4. The QI program should monitor the average timeframe for advanced level clinician face-to-face assessment after nurse referral, with a threshold of no more than five business days.

8. Emergency Care

Compliance Status: Substantial compliance.

Findings

We reviewed seven records of patients who were sent offsite on an emergency basis. In general, these patients were assessed timely prior to send out, an advanced level clinician was notified and recommended the patient be sent out, and when the patient returned the appropriate offsite documents were available and the patients were seen by a nurse upon return and by an advanced level clinician within a few days after return. In most of those follow-up visits, the findings and plan were discussed. However, we did find an occasional record where there was no documentation of contact with an advanced level provider as well as an occasional record where the offsite service document was missing. We also found an occasional record where the nurse note on return was absent and an occasional record where the follow-up visit with the advanced level clinician either did not occur or did not include documentation of a discussion with the patient regarding the findings and plan. Because we did not identify a pattern to any of these individual errors, we still assessed this area as substantial compliance.

Recommendations

1. The QI program should be monitoring a set of emergency offsite visits and insuring that there is documentation of a discussion with an advanced level clinician prior to send out and that there is a nurse note upon return, as well as both the available documents from the offsite service and a timely follow up by an advanced level clinician at which there is documentation of a discussion regarding the findings and plan.

9. Follow-Up Care

Compliance Status: Partial compliance.

Findings

We looked at scheduled offsite services, that is consultations and procedures, both at Alden and at the holding center. In both facilities, we identified multiple records where there was a breakdown in either availability of offsite service documents or in a timely follow up by the clinician in which there was documentation of a discussion with the patient regarding findings and plan. There were records at both sites in which all of the required elements were present. However, between the two sites the rate of records where all of the elements in the offsite service process were successfully completed was less than 50%. Therefore, the assessment of partial compliance.

Recommendation

1. The QI program should monitor at each site a sample of patients sent offsite for scheduled offsite services. The monitoring should include the timeliness of the appointment, the presence of the offsite service report upon return and the follow-up visit with an advanced level clinician in which they document the findings and plan having been discussed with the patient. When there is breakdown in any of these steps, the QI

program should assess the contributing factors and develop improvement strategies to mitigate the occurrence of these factors.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

In our last report we voiced concerns regarding the loss of the Medical Director and the ability of the program to therefore improve clinical performance. At this visit, with regard to chronic diseases, our concerns were realized. During this visit, we looked particularly at diabetes care and HIV care in order to determine whether problems we had identified in our prior visit had in fact been mitigated. In general, with some exceptions, we found that many of the prior stated performance issues have not been mitigated. The following is a list of those concerns.

We found patients for whom for the first visit, the initial baseline form was not utilized and as a result there was insufficient disease specific history. We also found records where only one of the chronic diseases was addressed and therefore the other chronic diseases appeared to have been ignored. We also found records where there was no assessment of degree of control, which ultimately determines the management approach. In the case of HIV disease, we found patients seen where at the initial visit there was no order for the viral load, although there was an order for the CD 4 count. The viral load is critical in order to determine viral activity. The CD 4 count may be within normal range, but if the viral load is significantly elevated, this may mean either that if the patient is on medications, resistance is possibly developing or in a patient not on medications, it is likely to indicate the need for initiating medications. With the absence of the viral load at the time the patient is sent to the HIV specialist, this may delay the ability of the HIV specialist to determine when treatment needs to be initiated. These types of problems hopefully will be easily addressed by the new Medical Director. If the program is able to develop a contract with the proposed Medical Director in the interim before he is to start as Medical Director, this could allow improvement in ALP performance over the next few months.

Recommendations

1. Send to the medical monitor the curriculum vitae of the proposed Medical Director,
2. Proceed with the administrative steps necessary to bring the proposed Medical Director on board in the interim to perform professional performance enhancement reviews.
3. The Director of Correctional Health Services should contact the medical monitor about designing a form to be utilized by the proposed Medical Director in performing the professional performance reviews.

11. Dental Care

Compliance Status: Substantial compliance.

Findings

We were not able to interview the dentist during this visit and therefore we were not able to review the program as thoroughly as during our prior visits. However, when we reviewed the data on performance of restorations versus extractions, we observed that the prior problem of one dentist overwhelmingly performing extractions has been eliminated. We were informed that that dentist has been terminated. We believe that it is important for the quality improvement program to track date of receipt of symptomatic requests that reflect tooth pain and date of face-to-face encounter either with a nurse or with dental staff during which analgesia is provided. We also believe that tracking of dental pain in relationship to assessment by a dentist should also be tracked.

Recommendations

1. The QI program should track symptomatic requests that discuss tooth pain and date of initiation of analgesia.
2. The QI program should also track date of request received describing dental pain along with date of assessment by the dentist. These studies should be reported monthly and reviewed at the QI meeting quarterly.

12. Care for Pregnant Prisoners

Compliance Status: Partial compliance.

Findings

During our last monitoring visit, we assessed the compliance status as conditionally substantial compliance. We have downgraded the assessment to partial compliance because two of the five records reviewed lacked the necessary offsite service documents to allow for appropriate continuity of care onsite. We understand that there has been contact with the Women and Children's Hospital administration regarding providing the necessary documents. However, the staff at ECHC and ECCF must persist in obtaining these critical documents. It may be that in addition to another meeting with the leadership of these offsite services that a letter from the Department of Health or Correctional Health Services be brought by an officer to the offsite service provider which indicates the officer must return with the required documentation in an envelope in order to facilitate continuity of care onsite and in order for the service to be completed, thus allowing for timely compensation.

Recommendations

1. Develop an administrative strategy that facilitates timely retrieval of the critical offsite service documents.
2. The QI program should continue to track timeliness of initial ALP assessment after determination of pregnancy as well as timeliness of offsite service obstetric visit from time of diagnosis.

13. Dietary Allowances and Food Service

Compliance Status: Partial compliance.

Findings

We were impressed with the dietitian who has been hired on a part-time basis to guide the food services operations. We had an opportunity to talk with her and learned that she has been assessing whether there could be a transition to a heart-healthy diet. We were informed that at the ECCF there was a well-designed and equipped kitchen and therefore they could convert to such a diet. On the other hand, at the holding center, the kitchen, which was built with the building several decades ago, was only designed for potential population of 200 detainees. Therefore, the size of the kitchen does not currently allow for the type of food preparation for a heart-healthy diet and rather requires the utilization of a significant amount of processed foods. This creates a challenge, particularly with regard to the salt content of the master menu diet at the holding center. It would be problematic to have one master menu at one facility and a significantly different master menu at the other facility. We also found that the number of detainees for whom both a diabetic diet and a cardiac diet were ordered was substantially less than what one would project for the holding center. This suggests that there is continued need to attempt to move to a heart-healthy master menu because accomplishing that goal would eliminate the need for special diets for diabetes and hypertension and thus increase the likelihood that detainees with these problems would receive an appropriate dietary regimen.

Recommendations

1. Bring in an appropriate consultant to determine whether the existing holding center kitchen can be expanded and equipped sufficiently to allow for a heart-healthy diet.
2. Provide the medical monitor with an analysis of the existing food served both at the ECCF and at ECHC so that the dietitian can determine how big a change moving to a heart health diet would cause.

14. Health Screening of Food Service Workers

This area has been in compliance for 18 months.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

The Director of Nursing, who has excellent prior experience, is currently functioning as the infection control nurse for both facilities. We discussed with her the infection control program in general and discussed in detail the TB surveillance program as well as the MRSA surveillance program. We also discussed data collection with regard to hepatitis A, B and C as well as HIV

disease. We would like to review the TB control policy which we had reviewed several years previously. We also learned that the ability to track skin infections presumptively treated for MRSA has not yet been implemented. The implementation of the electronic medical record should facilitate notification by clinicians to the infection control coordinator when such presumptive treatment occurs. This can be done internally through the EMR flagging system (internal e-mail).

Recommendations

1. Establish a system to monitor both culture proven and presumptively treated MRSA cases on a monthly basis.
2. Report both categories of MRSA cases at the QI meeting on a quarterly basis.

16. Sexual Abuse

Compliance Status: Partial compliance.

Findings

When we reviewed the records of patients who had historically alleged sexual abuse, we found that the documentation from the offsite services did not even mention the performance of a forensic exam nor the provision of rape crisis counseling services. We understood that discussions between the leadership of correctional health services and the leadership of ECMC have occurred and yet line staff from the offsite services are still not always providing the necessary documentation. We strongly urge a letter be drafted coming from the Department of Health to ECMC staff that describes the federal requirement that documentation of such services, including prophylactic treatment for sexually transmitted diseases and counseling regarding pregnancy, be included in the offsite service documentation. This letter should be brought by an officer for each and every patient who is to be assessed at the hospital via a forensic exam.

Recommendation

1. The Department of Health should develop a letter to the ECMC staff that documents the requirement of correctional facilities to be able to demonstrate documentation of the occurrence of both a forensic exam and rape crisis counseling along with the provision of sexually transmitted disease treatment and pregnancy counseling where indicated.
2. The QI program should track the receipt of this documentation for each and every allegation.

17. Quality Management

Compliance Status: Partial compliance.

Findings

In the absence of a Quality Improvement Coordinator, the Director of Nursing services is also attempting to perform these duties. We believe this is hindering the development of this program. Additionally, the Director of Nursing, in the absence of an assistant Director of Nursing for the ECCF, is also providing direct oversight to both facilities. Clearly, an Assistant Director of Nursing for the ECCF is also required. We reviewed the minutes of the quality improvement committee meetings and identified that the minutes read more like staff meeting minutes than QI meeting minutes in which data is presented and analyzed and, where indicated, improvement strategies are developed. We could not find these activities in the quality improvement committee minutes. On the other hand, we were shown some important studies performed.

1. A study of the timeliness of receipt by the patient of critical forensic medications. We found that 40 of 48 forensic medications labeled as critical were received within the forensic mental health definition of timeliness, that is within 24 hours. Eight patients received their medication later than 24 hours.
2. We also found a study of the timeliness of receipt of routine medications utilizing a definition of 48 hours. Thirty-seven of 44 patients received their medical medications within 48 hours. Seven patients had their medications delayed greater than 48 hours. Ten patients refused their medications at the time of receipt and all of these were referred to the advanced level provider.
3. There was also a completeness study of the elements during the intake process, such as the medical screen, patient consent, vital signs and detox referral where indicated along with medical classification, alerts and suicide screen.

These studies are important and helpful. However, in the recommendation section of this report we have also listed studies for the quality improvement program to perform dealing with care of the pregnant patients, sexual abuse cases, chronic disease cases, dental services, scheduled offsite services, unscheduled offsite services, and others. We believe it is not possible to perform all of these reviews without the addition of a Quality Management Coordinator.

Recommendations

1. Add both a Quality Management Coordinator and the Assistant Director of Nursing positions as soon as possible.
2. Work with the IT consultant regarding the ability to track critical elements through the EMR by re-customizing encounter forms where indicated.
3. Perform the studies referred to under the recommendations section consistent with the recommendations we have made.
4. Revisit the definitions for timeframe of receipt for critical medications for both medical medications and forensic medications. For medical medications that are critical, such as anticoagulants, anti-seizure meds and HIV medications, the goal is prevent dose discontinuity by insuring that the dose is received in a timeframe that mitigates the

probability of dose discontinuity. That is almost invariably in a timeframe significantly less than 24 hours. For routine medical medications, the goal should be receipt within 24 hours. Forensic medications may have a different timeframe and different targets. This should be worked out with the leadership of forensic medical services.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Non-compliance.

Findings

Since the departure of the Medical Director there has been no review of clinical care by a responsible physician. Thus the assessment of non-compliance. We are hopeful that the Director of Correctional Health Services can work with the medical monitor to design a system for professional review. We are also hopeful that between receipt of this report and the beginning of September this review can be initiated.

Recommendations

1. The Director of Clinical Services should initiated communication with the medical monitor in order to develop a systematic review of professional performance.
2. The Director of Correctional Health Services should contact a physician to perform this service.

III. Protection from Harm

E. Training of Officers with Regard to Sexual Abuse and Policy on Handling Sexual Abuse

Compliance Status: Substantial compliance.

Findings

Both the policy and the training are consistent with an assessment of substantial compliance.

Recommendation None.

I. Training of Medical and Mental Health Staff

Compliance Status: Substantial compliance.

Findings

Both the medical and mental health staff have completed their training with regard to the handling of sexual abuse. The percent trained is well above 90%.

Recommendation None.

J. Suicide Prevention Program

e. Privacy

Compliance Status: Substantial compliance.

Findings

See number 3 under Medical Care section.

Recommendation None.

f. Assessment of Inmates in Detoxification

Compliance Status: Substantial compliance.

Findings

The detoxification unit continues to function as a well-designed program.

Recommendation

1. The QI program should continue to monitor the compliance of the nursing staff in performing the CIWA assessments.

D. Training of Officer Staff with Regard to Suicide Prevention Training

Compliance Status: Substantial compliance.

Findings

This area remains in substantial compliance and has achieved sustained compliance.

3. Detoxification Training Program

Compliance Status: Sustained substantial compliance.

Findings

All of the required medical staff have had this training.

Recommendation None.

Summary of Findings

Although when one reviews the section headings and the compliance status assessed one sees, if anything, in a few categories there have been some setbacks. However, within the partial compliance category we have observed improvement in some sections, particularly scheduled offsite services and chronic diseases as well as access to care and the quality improvement

program among others. The method of assessment, choosing one of three statuses, does not allow for the description of the progress other than in the findings section. We continue to be impressed by the efforts by both the Department of Health and the Department of Corrections to do what is necessary in order to achieve substantial compliance. We are particularly impressed with the work by the Director of Correctional Health Services and the Director of Nursing, without whose work the progress that we observed would not have been observed. This was accomplished despite the loss of the Medical Director. We would hope that with the hiring of a new Medical Director as well as the implementation of an electronic record that we will see significant improvements at the time of our next visit. We continue to encourage the leadership of the medical program to utilize our services whenever they deem appropriate. We look forward to substantial progress at the time of our next visit.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

RS/kh