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Final Report To Proviso Work Group
Jail Health Services
Seattle-King County
June 10, 2003

SECTION 1:

DEVELOPMENT OF A DEFINITION OF "CONSTITUTIONAL MINIMUM" AS APPLIED TO THE KING COUNTY JAIL SYSTEM AND BASED ON CURRENT FEDERAL REGULATIONS AND LAW.

The Constitutional mandate for governmental officials to provide for the healthcare needs of prisoners is delineated in the 1976 ruling by the Supreme Court in *Estelle v. Gamble*[1]. In that interpretation, the Supreme Court found that prisoners have a Constitutional right to be free of "deliberate indifference to their serious healthcare needs." The ruling has subsequently been tested on numerous occasions and it has proven to be an extremely durable legal construct that still serves as the controlling piece of litigation with respect to correctional healthcare. One of the primary reasons for this ruling's endurance has been its generality. Unfortunately, that generality affords no easy answers to correctional healthcare professionals and requires individuals working in this field to rely heavily on interpretations of case law to help in determining systems and care guidelines that meet the standards that the Supreme Court had in mind.

Features That Describe Constitutional Correctional Healthcare Systems

The case law based on *Estelle v. Gamble* has served to establish the general construct that prisoners have three rights for correctional healthcare:

1. The right to access medical, dental, and mental health care
2. The right to receive professional medical judgment
3. The right to care that is ordered by a licensed professional practitioner

It is from these basic rights that the Courts have been able to define those features necessary in a healthcare delivery system to meet the Constitutional minimum[2].

1. Functioning sick call system
2. Properly trained and licensed personnel
3. Means of addressing emergencies
4. Methodology to assign priority to care
5. Development and maintenance of adequate medical records
6. Liaison with outside resources for specialty care / hospital care
7. System for staff development and training
8. Ongoing effort at quality control
9. Policies and procedures addressing special healthcare needs like disabled, geriatric, mentally ill, and HIV populations
10. Preservation of patient confidentiality

In the years after these features were promulgated, correctional healthcare administrators struggled with implementing the specific details outlined by the general principles. To that end, various methodologies and "standards" were published in the late 1970's, but it wasn't until the formation of the National Commission on Correctional Health Care in 1984 that a comprehensive set of specific healthcare standards was developed. These standards were major advances in correctional healthcare because they not only allowed administrators to measure their systems against the fully-defined Constitutional minimum for healthcare systems and they also provided some enforcement in terms of compliance.

Over the last twenty years, case law and NCCHC standards have evolved simultaneously and at this point in the history of correctional healthcare, a cogent argument can be made that the definition of a SYSTEM that meets the Constitutional minimums is a SYSTEM that is capable of passing NCCHC's accreditation process.

Constitutional minimums as they pertain to individuals

The discussion above focuses on systems only, and any discussion of Constitutional minimum would be incomplete without considering the status of individual patients who are treated within large systems. Unfortunately, having a system that meets Constitutional minimums affords only modest protection at the level of the individual patient from bad outcomes that can be successfully litigated as violations of the Constitutional mandate to provide care to prisoners. An analogy of this duality could be drawn from restaurants: While a restaurant may be a 5-star, highly-acclaimed restaurant from Zagat's, it is still entirely possible to contract a case of hepatitis A from eating there if one employee makes a mistake and does not wash his hands appropriately.

Unfortunately, an assessment of Constitutional minimums at the level of the individual is not as easily itemized as the foregoing list of features that define adequate Systems. In fact, an appropriate assessment of Constitutional minimums at the individual level is more easily conceived of as an analysis of "risk management" rather than as a "definition." To that end, further discussion about this will be deferred to Section 4 of the Proviso Report where a complete set of risk management suggestions is offered to assist Seattle-King County Jails in minimizing their risk profile to individual claims of deliberate indifference.

SECTION 2:

DEVELOPMENT OF A DEFINITION OF "MEDICAL NECESSITY" FOR CORRECTIONAL HEALTHCARE, BASED ON "CONSTITUTIONAL MINIMUM" REQUIREMENTS, NATIONAL COMMISSION ON CORRECTIONAL HEALTHCARE (NCCHC) ACCREDITATION REQUIREMENTS, AND PRACTICES AND DEFINITIONS FROM SIMILAR CORRECTIONAL HEALTH SERVICES OPERATIONS.

Medical Necessity is a subjective assessment of need based on objective findings. While this determination is not clear-cut in many cases, Wellcon recommends using the following philosophical construct to provide guidance in making this decision:

Primary Assumption: Jail is a short term environment and the mandate for healthcare in jail is to handle emergency situations, to diagnose and to treat serious medical needs, to prevent deterioration in preexisting conditions, to treat legitimate pain, and to prevent communication of disease or loss of function.

The decision points that should be taken into consideration when determining "Medical Necessity" include[3]:

1. Nature of the problem
2. How long the problem has existed
3. What the prisoner has done about the problem before
4. Nature of the proposed procedure or treatment and whether accepted medical standards support the proposed care
5. Urgency of procedure or treatment
6. Necessity of procedure or treatment
7. Potential complications for failing to treat
8. Availability of alternative treatment options
9. Expected remaining duration of incarceration
10. Probability of successful outcome of treatment including risk of adverse side effects
11. Expected functional improvement as a result of the intervention
12. Degree of compliance expected from the prisoner
13. Whether the intervention is for a pre-existing condition
14. Whether the intervention is a continuation of previous treatment or is the initiation of a new course of long-term treatment

The best methodology is to set up a committee that meets regularly to include the medical director, the health administrator, a representative from risk management, and any other

clinical staff as necessary to review patients in light of the above criteria. The medical director should solicit input from the individuals in attendance as well as any outside medical experts who it is felt are necessary in order to arrive at a collective decision for the facility with regard to care. If there is disagreement, the medical director retains full and final decision-making authority with respect to medical care issues. A summary of the meeting and the final disposition should be included in the patient's medical record as part of their healthcare treatment.

SECTION 3:

DEVELOPMENT OF A MODEL DESCRIBING AN APPROPRIATE SCOPE OF SERVICES FOR JAIL INMATES. THIS MODEL SHOULD BE DEVELOPED IN ELECTRONIC FORMAT AND SHOULD BE CAPABLE OF DETERMINING SCOPE AND LEVELS OF ADULT JAIL SERVICES BASED ON: 1)"CONSTITUTIONAL MINIMUM" REQUIREMENTS FOR ADULT CORRECTIONAL HEALTHCARE; 2) NCCHC REQUIREMENTS; AND 3) PRACTICES AND DEFINITIONS FROM SIMILAR CORRECTIONAL HEALTH SERVICE OPERATIONS.

What this question calls for is the development of a Utilization Review Model similar to what is used in insurance companies. Development of such a model for Seattle-King County is not possible at this time for the following reasons:

1. It is beyond the scope of this project in terms of timeline
2. It is beyond the scope of this project in terms of financial underwriting
3. Development of such a model presumes a baseline level of healthcare data that is nonexistent in the Seattle-King County Jail Health Services Unit

However, I will demonstrate such a model for you during the Proviso Meeting so that you can ask questions and see that a model similar to what you are asking for is indeed possible if the County invests the proper development time, energy, and financial backing.

SECTION 4:

AN ASSESSMENT OF HOW THE "CONSTITUTIONAL MINIMUM" COMPARES TO NCCHC ACCREDITATION REQUIREMENTS, AND HOW CURRENT ADULT JAIL HEALTH SERVICES COMPARE TO THE "CONSTITUTIONAL MINIMUM" AND NCCHC REQUIREMENTS.

Discussion of the relationship between "Constitutional minimum" and "NCCHC standards" has already been covered in Section 1 of this Proviso Report. To state the assessment again, at the level of Correctional Health Care Systems, the NCCHC standards were developed to enable Systems to assess themselves against what is considered to be the characteristics that define the Constitutional minimum as we know it at this point in time. In the sense that Seattle-King County Correctional Jail Health Services is accredited by NCCHC, a cogent argument can be made that the practices of your system meet the Constitutional minimum for systems. However, this assessment must come with the caveat that the accreditation process is subjective by its very nature and that a pattern of consistent accreditation over multiple surveys / surveyors represents the ideal scenario.

Section 1 of this report also discussed the fact that it is possible for individual patients to experience violations of their Civil Rights with respect to deliberate indifference to their serious healthcare needs even within systems that meet Constitutional minimums. To complete the discussion of Constitutional liability and NCCHC requirements at the level of the individual, it is most helpful to reframe the question into a more workable construct of "Risk Management." What follows is a breakout of risk management recommendations separated by major functional category within your health services system. It is my assessment of your system that you have many areas of potential liability but that they exist more at the individual patient level instead of the System level. Any restructuring of Jail Health Services should take these recommendations into consideration as effective ways of limiting your liability profile.

It is of critical importance to any reader of this report to understand the context in which the following recommendations are made. Jail Health Services runs a quality program that meets Constitutional requirements for delivery of healthcare to prisoners, and none of the following should be interpreted to suggest otherwise. While the comments that follow are expansive in their scope, the real value of this type of assessment is that it specifically addresses a relatively small zone of liability that can be further minimized by following the recommendations.

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Risk Management Recommendations
Seattle-King County Jail Health Services
June 3, 2003

Medical Records

1. Install an EMR. There is no practical or economical way to fix your paper chart library. Your medical record system is the single greatest liability that you have and if you took your current medical record to court the current state of your medical record would assist the plaintiff's case far more than it would assist in your defense.
2. Create a position for a medical records administrator (RHIT) and hire one for the jail. Your volume of medical records more than justifies a position.
3. You have no usable medical management data. Without that data, there is no way to monitor the system for quality while you are changing the system to achieve the desired cost-savings.
4. Until you have an EMR in place
   - Utilize chart dividers better to organize the charts that are in use
   - Create / implement physician order sheets and demand that all orders must be on those instead of in the progress notes
5. Hire transcriptionists and convert providers from hand-written notes to dictated notes
6. Schedule providers and hold them accountable for seeing what is on their schedule and account for anybody who was scheduled but not seen.

Nurse Staffing

1. Install an electronic medical record—documentation will improve dramatically.
2. Create high-level PHN Clinical Educator position to write training modules, certify new staff, complete orientation training
3. Dedicate training time within schedule for all new hires to cover orientation, skills pass off, and participating in mentoring with current employees.
4. Dedicate training time in schedule for monthly Continuous Nursing Education classes to be conducted under supervision of Clinical Educator.
5. Create high-level PHN Continuous Quality Improvement position to monitor the facilities and implement new initiatives.
6. Create high-level PHN Infectious Disease Nurse to implement and monitor infectious disease / lab issues. The first task should be to implement a comprehensive TB screening program.

7. Task nurses only to do all accept/reject and intake screenings instead of correctional officers.
8. Increase nursing treatments to be more consistent with community care standards.

Mental Health Nursing

1. Eliminate task-specific and site-specific nurse assignments and cross-train all nurses to work all areas of the jail.
2. Insist on appropriate inpatient documentation from Mental Health RN's
3. Redesign and implement appropriate documentation for Intensive Medical Management situations (forced meds, restraint, seclusion).

Psychological Evaluation Specialists

1. PES should cover the jails 24 hours a day, 7 days a week with one person in ITR / receiving unit and on person in inpatient mental health unit.
2. PES should serve as diagnostic consultants to include greatly expanded use of psychometrics within the inpatient units.
3. Stop the participation of PES in forensic procedures. They should serve a clinical role only to the prisoners of the jail, not a forensic role to the courts and to custody. That function should be contracted separately by the courts to maintain objectivity and professional distance.

Mental Health Inpatient Unit

1. Redefine what is considered to be inpatient-level care for mentally ill offenders within the jail. Many patients in the inpatient psych unit do not qualify for inpatient status and what you define as "inpatient mental health" is much bigger and more expensive than necessary. You need to concentrate your resources on the truly sick and minimize your resources allocated to the chronically low functioning (i.e., long-term stable resident in inpatient mental health still on 15-minute checks). Said another way, you undertreat the seriously ill and overtreat the chronically low functioning patients. Without management data and chart review data, it is impossible to focus on this problem with any more specificity than this general observation.
2. Patients to be admitted and discharged from unit only on provider order
3. Develop utilization review to make determinations on appropriateness of continued admission to inpatient status
4. Intensive medical management (restraint, forced meds, seclusion) deviates substantially from the current community standard and needs to be redesigned.
5. Develop process whereby medication can be compelled in the jail in cases that warrant it (with all due consideration to autonomy and the legal constraints that are created for patient safety). With the new classes of medications that have very minimal side effects, it is inhumane to allow someone to continue in a florid psychotic state indefinitely without pursuing this avenue.

6. Establish separate inpatient charts to include MD orders, MD progress notes, RN progress notes, social work progress notes, and treatment plans.
7. Psychiatrist / ARNP to perform admission history and physical exam within 24 hours
8. Psychiatrist / ARNP to round and chart on inpatients daily
9. Multi-disciplinary treatment plans to be completed
10. Psychiatrist / ARNP to complete discharge summary at time of discharge
11. Delegation of RN tasks to Correctional Officers needs to be done appropriately and with adequate documentation. In nursing, delegation of any care tasks (feeding, toileting, etc.) must be overtly done on each patient on each shift with documentation indicating who the task was delegated to and how they will be supervised.

Inpatient Medical Unit

1. Redefine what is considered to be inpatient-level care for medical offenders within the jail. Many patients in the inpatient medical unit do not qualify for inpatient status, but without management data and chart reviews it is not possible to quantify or characterize the extent of this impression any further at this time.
2. Patients to be admitted and discharged from unit only on provider order
3. Develop utilization review to make determinations on appropriateness of continued admission to inpatient status
4. Expand use of IV therapy on site.
5. Establish separate inpatient charts to include MD orders, MD progress notes, RN progress notes social work progress notes, and treatment plans.
6. Physician / ARNP to perform admission history and physical exam within 24 hours
7. Providers to round and chart on inpatients daily
8. Multi-disciplinary treatment plans to be completed
9. Providers to complete discharge summary at time of discharge
10. Providers in the inpatient medical unit to take care of all withdrawal patients housed there as part of their patient load.

Restraint / Seclusion of Prisoners

1. Rewrite policy and procedure to separate custody restraints and medical restraints completely. Jail Health Services should have no participation in "custody restraints" with respect to watching, checking, etc.
2. Eliminate use of restraint chairs completely in the facility. They are extraordinarily dangerous and their use is very commonly litigated.
3. Initiate dialogue between Jail Health Services, Risk Management, and Division of Professional Licensing about what levels of care are considered to be "community standard" with respect to intensive medical management and then write policy to reflect those standards.
4. Create documentation flowcharts that meet the above standards

5. Delineate clearly a forced medication / competency protocol and demand adherence for all situations
6. Cross-train medical and mental health nurses to ease staffing difficulties for this level of acuity.

Pharmaceutical Issues

1. Change practice of nurses so that every medication administered is reflected on the MAR.
2. Eliminate use of professional samples inside the jail and switch to using "vouchers" for medications so that you receive your credit without incurring the legal risks of managing the pills themselves.
3. Change packaging techniques so that every pill is unit-dosed and that no loose pills are sent out from the pharmacy.
4. Implement policy controls that all meds with narrow toxicity windows are "Direct Observe Therapy" by definition.
5. Institute random compliance surveys and report the results through Continuous Quality Improvement.
6. Improve training of nurses in proper medication management and discipline those who do not comply. Switching to all-unit-dose packaging will eliminate nurse repackaging completely.

Withdrawal Management

1. Consolidate process into a coherent treatment plan that focuses on objective measurements of patient condition and formalize the treatment protocols for this.
2. Apply assessment protocols over entire jail population who is at risk for withdrawal instead of just a few infirmary patients.
3. All withdrawal patients in the infirmary should be cared for in place by the clinician who is covering the infirmary.
4. If you want to manage this type of patient on-site, invest in appropriate lab diagnostic equipment to do it safely. At a minimum you should have complete blood counts and electrolytes available on site.
5. Expand care spectrum in infirmary to include IV fluid and medication therapy in order to manage these patients in a medically appropriate way.

Laboratory Services

1. Invest in a complete blood count machine (Coulter or Abbott) and electrolyte testing at a minimum if you want to continue to do inpatient care.

Disease Management

1. Expand role of medical director in committees, lines of supervision, utilization review, and approval of any nonstandard therapy.
2. Update all medical protocols for common conditions and publish those to the providers
3. Develop internal practices for disease management. For example, all insulin-dependent diabetics should have blood sugars 3-4 times per day instead of the current two.
4. Develop a utilization review process at the level of the medical director for all elective outside referrals (explained in detail in Section 2 of this Proviso Response)
5. Develop peer review process for mental health, dental, nursing, and medical providers, all of whom should answer to the medical director with summaries of findings.
6. Develop a process for reviewing / approving non-formulary medication requests at the level of the medical director.

Intake Screening

1. ONLY nurses trained in triage should do intake assessments. Officers are not properly trained for this assessment and will miss more pathology than they will catch.
2. Develop more intensive screening form to include vital signs and an appropriate screening physical exam.

Tuberculosis

1. Implement an Electronic Medical Record to track the hundreds of patients enrolled in this screening program at any given time.
2. Implement a true TB surveillance program that meets CDC guidelines ASAP. Failure to do so puts the County in a very precarious situation from a risk management standpoint as well as a public health standpoint
3. Place PPD's on every prisoner who enters the jail and read them all
4. Increase radiology services to meet the demand for Chest Xrays.

Policy and Procedure

1. Continue to re-write outdated policies and procedures
2. Combine Medical, Mental Health and Dental policies and procedures into a Jail Health Services Unit Policy and Procedure manual for all facilities.
3. Incorporate standards of practice for most common situations in P/P
4. Train all employees on new P/P and test to show comprehension
5. Design new P/P as new services (inpatient medical, comprehensive RN screening, computerized records, etc.) are developed and brought on-line.

Continuity of Care

1. Install an electronic medical record system
2. Design discharge sheet for all prisoners to receive upon rollup (best done with an EMR to minimize labor)
3. Make the medical discharge part of the rollup process
4. Improve process for prisoners taking medication with them at the time of release from jail. This will require improving the interface between DAJD and JHS and working out appropriate procedures to enable this program to succeed.
5. Increase productivity of physicians and mid-level providers to open up clinical appointments for the chronically ill.

Access to Care

1. Credential RN's to perform triage appropriately
2. Limit triage to once per day by RN's
3. Forbid any paper triage by providers. They are responsible to see or disposition all patients on their schedules for the day.

Suicide Screening

1. Nurses exceeding scope of professional licensure by independently dispositioning mental health patients, particularly on 3rd shift.
2. Staff PES over all 3 shifts and use them as resources for final disposition on all mental health issues.
3. Implement suicide screening tool after appropriate staff training has been accomplished on how to use the tool
4. Do serial examinations on at-risk prisoners using the assessment tool
5. Eliminate screeners from the evaluation and intervention process and demand that psychiatrists / psych ARNP's see patients who are placed in acute management in a timely fashion.
6. Implement a suicide step-down process that is controlled by psychiatrist / ARNP order only.

Prisoner Workers

1. Hire Janitors for Health Services because prisoners are not allowed to clean or access patient care areas or to handle patient care equipment. In addition, prisoners do not have adequate training to clean biohazard contamination.
2. Make sure officers train workers outside of HSU to perform the tasks that are required and document that training
3. Purchase and provide adequate protective equipment for prisoner workers to meet OSHA guidelines.

Employee Health

1. Contract for an occupational nurse service or a separate contract with Public Health using a nurse not staffed through JHS for Sheriff's Office employees to handle all employee-related health issues including flu shots, hepatitis shots, TB tracking, yearly pulmonary function testing of all employees who might use SCBA's, significant exposure testing and documentation, etc. It is an unacceptable breach of confidentiality for anyone who works in the jail (JHS nurses) to be handling employee health issues outside of an emergency situation.

Blood Borne Pathogens

1. Contract with an approved cosmetology provider for all haircuts and shift the liability of proper decontamination onto their professional license.

Medical Equipment

1. Set up a contract for Biomedical Engineering service on all medical devices that contact a patient.
2. Consider hiring an equipment / computer specialist to handle the volume of repairs, servicing, supplies at the jails.
3. Purchase more AED's of the variety that produce a rhythm strip and have them more readily available throughout the facility. At a minimum, there should be an AED in all inpatient units, ITR, the clinic, and on each floor.

Dental Care

1. Develop more definitive dental guidelines for treatment
2. Involve dentist more fully in ongoing quality assessment practices
3. Look at outcomes of his care vs. more aggressive care for certain disease processes.
4. Train all nurses who perform triage in dental triage

Continuous Quality Improvement

1. Hire a dedicated CQI nurse to run this process.
2. Install an Electronic Medical Record system to assist in collection of appropriate clinical data upon which to base CQI investigations.
3. Base CQI on systematic investigations of charts, patients, data, environmental conditions, etc., not just on "putting out fires."

Medical Isolation Procedures

1. Admission and discharge from isolation status done only by provider order.
2. Any prisoner in isolation must have labels on door as to type of isolation: "Respiratory," "Body Fluid," as well as the type of isolation gear needed by anyone entering the room.

Radiology

1. Increase radiology to meet the needs of the facility

SECTION 5:

RECOMMEND ACTIONS FOR REDUCING HEALTH CARE COSTS IN THE KING COUNTY JAIL BASED ON BEST PRACTICES AND CURRENT NCCHC ACCREDITATION REQUIREMENTS. ALL ANALYSIS WILL CONSIDER THE SIZE AND COMPLEXITY OF KING COUNTY JAIL HEALTH POPULATION.

The following recommendations are mandatory requirements for any successful restructuring project to have any chance of succeeding:

- Establish Clinical Leadership Team
    1. Hire a Administrative Assistant / Confidential Secretary to share between Health Administrator, Medical Director, and Director of Nursing.
    2. Create a Director of Nursing position to cover all nurses between both facilities.
    3. Hire to a total of 3 PHSS nurses and turn them into true house supervisors covering both facilities when on shift / on call.
    4. Eliminate APHSS positions since their functions will be subsumed into the Director of Nursing, PHSS, and high-level Clinical Nurses.
    5. Create high-level PHN Clinical Educator position to write training modules, certify new staff, and complete orientation training.
    6. Create high-level PHN Continuous Quality Improvement Nurse to monitor the facilities and implement new initiatives.
    7. Create high-level PHN Infectious Disease Nurse to implement and monitor infectious disease / lab issues. Her first task should be to implement a reasonable TB program.
    8. Do not separate facilities administratively, staffing, or functionally. They should function was one facility with one administration just separated into two buildings.

The items that follow are a combination of recommendations and possible options for restructuring. Many of these items require choices to be made by the Clinical Leadership Team identified above and priorities can be assigned to the items after those choices have been made. It is important to note that some of the items listed below may be mutually exclusive depending on the choices made, but all of them are viable options to consider in reducing cost. Additionally, many of the items below require coordination with the changes occurring on the custody side and it is imperative that the Clinical Leadership Team have frequent and comprehensive contact with those individuals participating in the formulation of the Operational Master Plan for the jail so that each group can benefit from economies of scale.

- Invest in an Electronic Medical Record System
    1. Provides pertinent healthcare management data.
    2. Improves efficiency of multitudes of internal processes.
    3. Automates many healthcare functions thereby reducing staffing needs
    4. Increases productivity of all staff.
    5. Eliminates duplication of effort.

- Renegotiate Contracts with Unions
    1. Eliminate extensive lunchbreaks that limit productivity.
    2. Move nurses to 12-hour shifts.
    3. Redefine supervision rules to match with medical model of care.
    4. Create explicit language regarding management's ability to have employees to float according to needs of facility.
    5. Reconfigure the benefits ratio for 0.5 FTE vs. 1.0 FTE and steps in between so that it is a sliding scale, not an absolute full benefits at 0.5 FTE.

- Reconfigure Nursing Staffing
    1. Implement an EMR to perform many of the tasks automatically that are now done manually by nurses—tracking, documenting, etc.
    2. In conjunction with changing methodology of medication packaging, retask / hire sufficient Pharmacy Tech positions to free up RN's from medication passing duties.
    3. Retask freed up positions to perform intake assessments in ITR.
    4. Cross-train all nurses to work in all areas of the jail and eliminate task-specific and site-specific nursing assignments. This is most evident in mental health but it should be eliminated facility-wide.
    5. Change nursing shifts to 12-hour shifts throughout facility.
    6. Eliminate self-scheduling of RN's with respect to daily duties. They should all have discrete task lists that are monitored for productivity.
    7. In conjunction with redefining the inpatient mental health unit, decrease nursing staffing in that unit accordingly.
    8. Conceptually, JHS would be best served to move away from LPN's and hire RN's selectively because of their ability to function independently without additional supervision.
    9. Hire unit clerks for clinic, ITR, and inpatient units to free nurses up from clerical duties.
    10. Limit nursing triage to once per day.
    11. Reclassify medical unit at RJC and treat it as merely prisoner housing for staffing needs.
    12. In conjunction with custody functions, develop policy and procedure to enable medical to place a "medical hold" on all prisoners requiring high level medical interventions such that they could not be transferred to RJC.
    13. Consider operating RJC as a jail for ambulatory and healthy prisoners only and adjust nursing staffing accordingly. This is a policy decision and if it is felt to be inconsistent with how the County wants to operate RJC then accept

the increased costs of operating higher acuity units at both KCCF and RJC as a tradeoff.

14. Eliminate concept of "unrelieved posts" except in the acute care units. To be effective in staffing healthcare facilities, administrators must have the ability to float nurses to other areas to meet demands.
15. After above issues are implemented, it is reasonable to think that JHS could significantly reduce its nursing staffing overall.
16. Work to eliminate overtime and agency nurses.
17. Eliminate 0.5 FTE nurses with full benefits. This is a very costly luxury that far exceeds community standards.

- Reconfigure Psychological Evaluation Specialist staffing
  1. PES should cover the jails 24/7/365 for the purposes of performing crisis intervention and serving as a resource for the mentally ill.
  2. PES should serve as diagnostic consultants in the inpatient mental health unit.
  3. PES coverage of RJC should be by phone if you successfully convert RJC into a healthy ambulatory facility that does not do intake assessments.
  4. Eliminate routine use of PES in ITR—they should consult on patients only if referred by nursing during the intake assessment.
  5. Minimize number of psychologists on PES staff in favor of clinically-licensed mental health workers.

- Change physical plant
  1. All changes in this section need to be coordinated with the Operational Master Plan of the jail.
  2. Redesign West Wing to be a true medical unit. This would increase efficiency to some degree.
  3. I do not see the current physical plant as impossibly limiting although improvements could be made.
  4. Decrease physical size of inpatient mental health and turn one of the areas into a mental health stepdown unit with an appropriate treatment milieu.
  5. Turn RJC medical unit into regular prisoner housing with no medical component and consolidate as much of the medical enterprise at KCCF as possible.

- Physician Staffing
  1. Investigate ability to contract with part-time physicians in specialty areas of high utilization to perform clinics on-site.
  2. Provide differential pay to physicians but demand productivity.
  3. Eliminate 3rd level of triage performed by providers (first two provided by nurses).
  4. Schedule all providers with an actual daily schedule instead of allowing them to self-schedule their days.
  5. Staff a nurse in clinic to provide healthcare support for medical providers
  6. Staff a unit clerk in clinic to provide secretarial, scheduling, paperwork support for medical providers

- Change Inpatient Mental Health Unit Practices
    1. Redefine what is considered to be inpatient-level care for mentally ill offenders within the jail. Many patients in the inpatient psych unit do not qualify for inpatient status and what you define as "inpatient mental health" is much bigger and more expensive than necessary. You need to concentrate your resources on the truly sick and minimize your resources allocated to the chronically low-functioning. Without either an EMR to provide cogent management data or detailed chart reviews it is not possible to characterize this problem further at this point.
    2. Develop utilization review to make determinations on appropriateness of continued admission to inpatient status.
    3. Develop process whereby medication can be compelled in the jail in cases that warrant it (with all due consideration to autonomy and the legal constraints that are created for patient safety).
    4. Reduce nursing staffing in inpatient mental health unit in accordance with reorganized levels of care.
    5. Turn part of inpatient mental health into a therapeutic milieu stepdown unit.
    6. Reduce officer staffing in inpatient mental health in accordance with reorganized levels of care.

- Change Inpatient Medical Unit Practices
    1. Redefine what is considered to be inpatient level care for medical offenders within the jail. Many patients in the inpatient medical unit do not qualify for inpatient status.
    2. Develop utilization review to make determinations on appropriateness of continued admission to inpatient status.

- Modify Pharmacy Practices
    1. After analysis of your pharmacy situation I do not advocate for privatizing your pharmacy as an isolated carve-out. Your pharmacy acquisition costs are competitive, you wish to run a methadone clinic on site which requires a pharmacist and you have the space available to consolidate services, and you have to repackage a lot of sample medications.
    2. Carefully consider the implications for continuing to rely on physician samples from pharmaceutical companies. In the least, account for the value of these medications in all assessments of pharmacy costs so that decision-makers have a complete picture of your pharmaceutical practice.
    3. Consolidate pharmacy into one site.
    4. Change pharmacy practices so that every pill dispensed within the jails is in unit-dose format.
    5. Purchase equipment necessary to blister-package all medications into unit doses.
    6. Expand your Keep-On-Person medication program.

7. Reduce nurse pill pass to include only direct-observe meds and injections only. Regular pill pass can be reduced to twice-a-day instead of the currently 3 to 4 times per day.
8. Eliminate Over-the-counter medications from nursing and pharmacy responsibilities and place them all on commissary.
9. Provide discharge medications to mentally-ill prisoners of at least 7 days to help with recidivism issues.
10. Implement and enforce a facility formulary in conjunction with Medical Director / Chief of Pharmacy

- Consider privatizing all or parts of healthcare enterprise
  1. From purely a cost analysis perspective this is a reasonable recommendation.
  2. This is not a magic solution as there are many potential problems that go along with any potential gains
  3. The County still retains all of its civil liability under this option and it may lose some control over its ability to limit that liability
  4. Politically this may not be possible and I won't expand on it unless requested.

- Medical Director Oversight
  1. Empower medical director appropriately to monitor all care in the facility.
  2. Bring all mental health, dental, pharmaceutical, and laboratory functions under supervision of medical director.
  3. Establish a Utilization Review Committee chaired by the Medical Director as described earlier in this document.
  4. Expand role of medical director in JHS committees, lines of supervision and treatment decisions.
  5. Develop a peer review process for all areas of practice but supervised by the medical director.
  6. Develop a prescription profile for all providers to help delineate prescription habits. The sheer number of prescriptions ordered in this facility is staggering and needs to be brought into some semblance of control.

- Laboratory practices
  1. Eliminate Gram staining of samples on site. It is wasteful of time and medically it is far below the standard of care for assessing sexually transmitted diseases.
  2. Invest in the ability to run common labs on-site: complete blood count, electrolytes, etc.

- Substance Abuse Counselors
  1. Eliminate them from the JHS budget.
  2. Seriously reconsider their efficacy in a jail setting with a very limited length of stay.
  3. Move their services into the community and open up ample opportunities for enrollment of prisoners referred from mental health / medical staff within the jail.

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SECTION 6:

RECOMMEND PERFORMANCE INDICATORS IN A CONTRACT BETWEEN DEPARTMENT OF ADULT AND JUVENILE DETENTION (DAJD) AND JAIL HEALTH SERVICES (JHS) FOR CORRECTIONAL HEALTH CARE.

Report Given to DAJD from JHS About Medical Care

- Number of officer transports and distribution by specialty / emergency
- Number of suicide attempts
- Number of medical bad outcomes
- Number of medication errors
- Number of medical grievances, categorization, and disposition
- Aggregate infectious disease data about surveillance and actual interventions
- Average census in inpatient psych, inpatient medical, negative air, on suicide watch, and number on q 15 min watch
- Distribution of diagnoses for all patients admitted to inpatient status
- Clinic visits for nursing, providers, dental, mental health
- Number / type of nonformulary meds used
- CXR's done
- Number of medical appointments not kept and reason why
- Number and type of staff vacancies
- Budget information broken out in a variety of ways
- Compliance with meetings, cooperative efforts, etc. to include minutes
- Documentation of compliance with the contract items listed in the last section of this report. Usually this is done in report format either once or twice a year as part of the audit.

Report Given to JHS by DAJD Regarding Interface with Medical

- Number of intakes
- Population statistics—average length of stay, distribution of security classification, etc.
- Number of hospital days requiring guarding
- Number of ambulance transports
- Number of overtime hours for officers doing medical guarding
- Critical incidents from watch command
- Copies of completed environmental surveys to include checking negative air, water temperatures, SCBA pressure checks, first aid kit checks, and anything else agreed upon in the contract.

SECTION 7:

A RECOMMENDED MECHANISM FOR OVERSEEING PERFORMANCE ON THE CONTRACT BETWEEN DAJD AND JHS.

The only way to oversee performance on a contract is to perform audits on the terms of the contract on a set frequency and to generate reports summarizing the findings of those audits. My recommendation would be to establish an internal committee to perform these audits using agreed-upon audit criteria and to develop reports regarding the results of that audit process. The audit criteria should be developed as part of the contract so that the content and format are spelled out and contractually established.

If the contract is well written and accurately reflects the understanding of both sides, then monitoring the contract using internal committees should be easy to accomplish since compliance should be very high. Routine monitoring would be accomplished using internal committees comprised of JHS and DAJD members with sign-off from each group on the final report to include comments if necessary. That report would be given to the executives who supervise JHS and DAJD and if everything is working well, then no further action would be necessary. If things are not working well, then it would be up to the supervising agencies to decide what steps are necessary.

SECTION 8:

A DEFINITION OF THE MINIMUM HEALTH SERVICES INFORMATION AVAILABLE (DATA REQUIREMENTS) FOR CONTRACT PERFORMANCE MONITORING BASED ON IMPLEMENTATION OF CURRENT DEPARTMENT INFORMATION SYSTEMS.

The Health Services information that is available is rudimentary at best. Jail Health Services has virtually no usable healthcare management data. To the extent that it is available, the data requirements from Jail Health Services are delineated in Section 6 of this report.

Ideally Jail Health Services would have a much richer statistical picture of their services more along the lines of what is listed below:

➢ *System Performance Measurements*

1. Number of prisoners seen medical outpatient sick call per day
2. Number of prisoners seen on medical inpatient rounds per day
3. Number of prisoners seen on mental health outpatient sick call per day
4. Number of prisoners seen on medical inpatient rounds per day
5. Number of prisoners seen on dental sick call per day
6. Time between submission of health care request and provider visit
7. Percentage of missed followups for scheduled appointments
8. Readmission rate to inpatient status within 30 days by ICD-9 code
9. Readmission rate to inpatient status within 90 days by ICD-9 code

➢ *Health Provider Profiling*

1. Number of prisoners seen per day
2. Chart completion
3. Cost per provider per prisoner visit
4. Percentage deviation from formulary
5. Percentage deviation from ideal clinical note writing
6. Number of in-house referrals per provider per month
7. Number of outside referrals per provider per month

➢ *Nursing Profiling*

1. Number of treatments per day
2. Number of medication / treatment errors per month
3. Number of assessments per day
4. Percentage of noncompliance to MD orders
5. Percentage deviation from nursing treatment protocols per month

➢ ***Disease Monitoring***

1. Number of Reportable Diseases (as defined by CDC / Utah State Department of Health) identified, date, and documentation of reporting
2. Number of PPD skin tests placed
3. Number of PPD skin tests read
4. Number of PPD skin tests that are positive
5. Number of active tuberculosis cases managed per month and per year
6. Number of HIV+ patients in-house per month
7. Average CD4 counts of HIV+ patients per month
8. Average viral load of HIV+ patients under treatment tracked over time
9. Number and diagnosis of AIDS-related complications per month
10. Number of culture-positive STD diagnoses per month and documentation of treatment
11. Number of Hepatitis A cases and monitoring of liver function tests per patient
12. Number of Hepatitis B cases
13. Number of Hepatitis C cases
14. List of Type I diabetics per week with blood sugar data retroactive for the last week, Blood Pressure Data, weight, latest Hemoglobin A1C level, insulin doses, and caloric level of diets.
15. List of Type II diabetics with blood sugar data retroactive for the last week, Blood Pressure Data, weight, latest Hemoglobin A1C level, insulin doses, and caloric level of diets.
16. List of seizure patients per week with latest medication levels and Complete Blood Counts and/or Liver Function Tests
17. List of hypertensive patients with medications and most recent BP data
18. Number of suicide gestures vs. serious attempts per month
19. Number of forced-restraint or forced-medication patients per month
20. Baseline ICD-9 diagnosis breakout and statistical comparison of deviation from the norm for any diagnosis code

➢ ***Individual Patient Profiling***

1. Identification of high risk patients by ICD-9 code diagnosis or pharmacy information
2. Identification of high utilization patients for behavioral staffing
3. Identification of patient refusals
4. Identification of special needs patients for ADA assistance, religious – medical conflicts, or special consideration
5. Calculation of cost-equivalent care in the private sector per prisoner

SECTION 9:

DEVELOPMENT OF A CONTRACT BETWEEN DAJD AND JHS BASED ON DEFINITIONS AND FINDINGS FROM ITEMS 1-8.

The items listed below are those items in a contract between DAJD and JHS that would focus on the functional components of the delivery of healthcare and maintenance of the custody/healthcare interface. All of these need to be considered and appropriate language needs to be developed by attorneys to assign responsibilities as appropriate. I have divided the responsibilities along lines that are traditionally seen in correctional facilities, but deviation from these assignments is possible. There are several items at the end that could be handled by either group and they need to be investigated and assigned as appropriate at the time of writing this contract.

Jail Health Services (JHS) Responsibilities

- Attendance at DAJD chief's meeting by health administrator and medical director
- Medical director job defined better with oversight over all clinical care
- Send representative from JHS to policy committee for DAJD
- Notification to officers of isolation precautions
- JHS has separate policies and procedures that DAJD signs off on
- Train officers in privacy of care / HIPAA
- Train officers in suicide / mental health issues / blood borne pathogens
- JHS will not participate in any employee health care except emergencies
- JHS will set aside training time for new employees to be trained in safety and security measures by DAJD
- JHS will contract separately or by agreement with other county agencies to manage refills on medical-grade oxygen as well as appropriate testing and storage of cylinders
- Define staffing, frequency and times of clinics, pill lines, and other healthcare items that impact custody staffing or flow of prisoners
- Review JHS policies and procedures at least yearly and send to DAJD for their review
- Establish utilization review committee to evaluate appropriateness of sendouts for external care and the appropriateness for transfer back to the facility from the hospital to minimize impact on DAJD staffing and transports
- Biohazard waste disposal methods and who is responsible
- Sharps waste disposal methods and who is responsible

Joint Responsibilities

- Develop joint policy on orthoses, prostheses, and other assistive devices
- Develop joint policy on forensic information (PES!)
- Formalize disaster drill training coordinated between both agencies
- Develop joint policy on use of restraints

DAJD Responsibilities

- DAJD will contract separately with Public Health for all employee PPD testing, Hepatitis shots, significant exposures and any employee health issues
- DAJD will contract separately or within County to service and recharge SCBA's after use
- DAJD will send a representative to JHS CQI and ID meetings
- DAJD will agree that only JHS licensed independent practitioners can admit/discharge from inpatient status / negative air (i.e., not correctional officers)
- DAJD will set aside training time for officers to receive health-related training
- Environmental control inspections presented to JHS personnel at scheduled times
- DAJD will present kitchen inspections presented to JHS personnel at predefined intervals
- DAJD will provide orientation to security for new JHS staff
- JHS will become part of discharge process from jail—summary, meds, appointments, etc—provide mechanism to put items in prisoner's property bag for his discharge
- DAJD officers will participate in multispecialty treatment team meetings for inpatient units
- DAJD will provide space for AED's / crash carts / gurneys
- Establish a formal liaison from DAJD for JHS and that person attends JHS administrative meeting q month
- DAJD will provide appropriate physical space, phones, copiers, etc as necessary for the mission of correctional healthcare
- DAJD will define for JHS those times and situations were patients must be locked down, unavailable, etc.
- DAJD will assist in meeting compliance standards for NCCHC for all things in DAJD control
- DAJD will provide appropriate guarding for all prisoners and will ensure that no employee of JHS is ever inappropriately unattended with a prisoner
- DAJD will provide all medical diets ordered by JHS providers
- DAJD will make provisions for all ordered healthcare including prostheses, medical beds, wound care, isolation, etc.
- DAJD will include JHS in the planning and implementation of the new technology communication infrastructure to make sure that it meets JHS needs for the future
- Housekeeping responsibilities for all medical areas
- Maintenance of first aid kits throughout facility
- Monitoring of negative pressure cells, water temperatures, environmental issues

REFERENCES

[1] *Estelle v. Gamble* 429 US 97, 97 SCt 285 (1976)
[2] Rold WJ. Legal considerations in the delivery of health care services in prisons and jails. In: Puisis M, ed., Clinical Practice In Correctional Medicine. St. Louis, MO: Mosby; 1998:344-54.
[3] Faiver KL. Health Care Management Issues In Corrections. Baltimore, MD: American Correctional Association; 1998:69-82.